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ABSTRACT

These hearings examine ways of ensuring access to quality health care, especially for low-income persons ineligible for Medicaid. The problems of determining who the economically disadvantaged are, what services they are provided with, and how those services are provided and financed are all addressed. An Urban Institute researcher testifies that the number of uninsured Americans under 65 increased between 1979 and 1982 largely because of the recession, and calls for more diverse forms of insurance. A representative of the Colorado Task Force on the Medically Indigent then presents findings that one-third of Colorado's population is neither publicly nor privately insured. A Kansas Women's Equity Action League representative describes the problems of access and affordability for women between 45 and 65 years of age. A representative of the Health Insurance Association of America testifies that 10 to 15 million Americans under 65 had neither public nor private coverage in 1982 and elaborates on the problem of uninsurables and attempts, via open seasons on insurance and pool systems, to remedy the problem. A statement by the American Protestant Health Association on Health Care for the Economically Disadvantaged urges the need to identify criteria for providing assistance to "safety net" hospitals and a final statement by the National Association of Chain Drug Stores criticizes current regulations covering reimbursements for prescribed drugs and offers suggestions for change. (RDN)

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S. HRG. 98-861

HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED

ED257911

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

APRIL 27, 1984

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HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED

FRIDAY, APRIL 27, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:34 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger and Heinz.

[The press release announcing the hearing follows:]

[Press Release No. 84-131]

HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the delivery of health care to the economically disadvantaged.

The hearing will be held on Friday, April 27, 1984, beginning at 9:30 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing Senator Durenberger noted that, "This is one in a series of hearings to examine how to reach our goal of ensuring access to quality care. In many cases, those low income persons who are ineligible for Medicaid are 'falling through the cracks' of our health care delivery system. In beginning to address this problem, we must detemine who is economically disadvantaged, what services they are now provided, and how those services are provided and financed. Later in the series of hearings we will focus on identifying what changes need to be made with respect to both the public and private sector to ensure access to needed health care."

Senator Durenburger stated that the Subcommittee is interested in hearing from the Administration with respect to an overview of individual State's Medicaid eligibility and the scope of services provided; from the States, greater detail as to who is not currently covered by Medicaid and, more importantly, as to whether and to what extent other State programs are used to provide needed care: and from the Congressional Budget Office, the extent of the population of economically disavantaged lacking access to health care. Additionally, the Subcommittee is interested in any additional data or studies which help define the population or the extent to which health care is or is not available. Where care is made available, the Subcommittee is interested in hearing from the entities that finance that care. This includes local government units, community service organizations, hospitals, physicians, clinics, and others.

Senator DURENBERGER. The hearing will come to order.

One of the primary objectives that I have set as chairman of the subcommittee for 1984 is to identify the problems faced by economically disadvantaged persons in America in receiving health care. And, hopefully, by the end of this process of identification, we still start another process to outline a solution to their problems.

We have spent a great deal of time in the Congress recently puzzling over how health care can become more affordable for the average American. And we have made some progress in finding the answers to those questions.

We have set into place a reimbursement system under medicare that will make hospitals in America more price conscious, and, hence, more price competitive. We have allowed State medicaid programs to experiment with competitive contracts for primary care providers in the community. We are also encouraging the expansion of capitated systems, such as HMO's. And we have worked closely with business and industry to learn from their efforts at cost containment.

But affordable health care for most Americans is still too costly for many. There remain a large number of Americans who are not protected from the high cost of a medical incident. These are not necessarily the very poorest among us; those who probably meet the eligibility criteria for most State medicaid programs. But rather they are those economically disadvantaged who live on the margin between poverty and our so-called middle class status.

A medical incident could have disastrous financial consequences for such people. We are here today to learn more about who are the economically disadvantaged in this marketplace. Once we better understand why people are unprotected against medical risk, perhaps we can then think about the most appropriate remedies that would insure each of them access to care when each of them needs it.

In subsequent hearings we will look at where the economically disadvantaged receive their care when they require it, and how the services they receive are provided and how they are financed.

So with that brief statement, I would like to thank all of the witnesses who have agreed to join us here this morning. Most of you are here because you are our backgrounders. I mean you are the people that have as broad an overview of the nature of this problem as we could find. You know what you are talking about, and I think you know a lot about the problem.

So rather than trying to start out with a bill that solves problems, we are going to start out with people that we think understand the nature of the problem and then we will go from there in trying to find a solution. So we will start this morning with Dr. Katherine Swartz from the Urban Institute.

Kathy, we have your full statement, which will be made part of the record. And you may do as you please with that statement. You may read the whole thing or summarize it or whatever you think will be most appropriate.

STATEMENT OF DR. KATHERINE SWARTZ, RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, D.C.

Dr. SWARTZ. Thank you for the opportunity to share some of our recent findings concerning the group of Americans who do not have health insurance. I have three major points which I would like to discuss.

First, the number of Americans under age 65 who do not have health insurance increased by a third between 1979 and 1982,

which reverses a 30-year trend. In 1979, 28.7 million Americans, or roughly 14 percent of those under age 65, lacked public or private health insurance. By 1982, the number had grown to 38.6 million, or 19 percent of those under age 65.

The second point is that the increase is due in large part to the 1981–82 recession. The direct effect of the recession, of course, was that many people lost their jobs and thereby lost health insurance for themselves and their dependents. But the recession also had an indirect effect which I think is perhaps more important. That is, it caused many firms to look hard at their escalating health insurance costs. Firms are now requiring employees to pay a larger share of the premium as well as more of the direct costs of health care. This has, in turn, caused workers, of course, to look hard at their expense for health insurance, especially for family coverage, which many have decided to drop. The increase in the number of uninsured Americans——

Senator DURENBERGER. You have some substantiation for that?

Dr. SWARTZ. Yes, I do. And I will elaborate on this point.

The third point that I would like to make is that I think this recent increase in the number of uninsured people adds to the urgency for the need for more diverse forms of insurance. In particular, I think greater availability of catastrophic health insurance is needed, which would address the group of Americans you were talking about in your opening statement.

In terms of the uninsured people that we see now, by 1979 almost everyone who was a permanent employee of a firm with 100 or more workers had health insurance. Family coverage was also usually purchased through employment—either by the firm in industries where unions were strong, or by the worker—because the large firms could obtain relatively low rates for family coverage.

Well, who in 1979 did not have public or private health insurance? Among the adults, one-third had worked fulltime for 40 or more weeks in 1979. The evidence certainly suggest that many uninsured adults worked for small firms that pay low wages and that do not offer health insurance as a fringe benefit.

The uninsured in 1979 were not predominantly in the lowest part of the income distribution. Instead, the largest group of them came from families that could be termed "working near poor." Almost half of the uninsured had family incomes between 100 and 300 percent of the poverty level. Only one-fourth had family incomes below the poverty level.

The children of such people, of course, were also uninsured. Almost 40 percent of the uninsured in 1979 were children.

In 1982, the last year for which we have data, the effects of the recession are clearly evident. Only one-fourth of the uninsured adults were full-time workers for 40 or more weeks in that year.

Adults who said they were looking for work increased from 8 percent in 1979 to 14 percent in 1982. This fall in labor force activity is seen again when we look at the uninsured by family income. While the proportion of the uninsured who had family incomes between 100 and 300 percent of the poverty level was almost the same as in 1979, the proportion who had family incomes below the poverty level increased to almost one-third.

It's important to note that the 1981-82 recession caused many families to lose their health insurance when primary earners lost their jobs. Last summer, much attention was focused on a study which used the 1977 National Medical Care Expenditures Survey, sometimes known as NMCES. Most of the unemployed in the NMCES study did not lose their health insurance coverage. The crucial difference to note between 1982 and 1977 is that the economy was in recovery in 1977. Those who lost their jobs in 1977 were typically secondary earners in families whose health insurance was provided by the other earner's fringe benefits, or they were employed in the service sector where health insurance was not offered as a fringe benefit, and they didn't have it to lose.

The recent recession hit the durable goods and manufacturing sectors hardest where health insurance is a widely held benefit. Significantly, only half of the jobs lost in the manufacturing sector in 1981-82 have been regained to date.

In 1982, children accounted again for about 40 percent of the uninsured. This also means that more than one out of five American children was without public or private health insurance in that year. There is a troublesome aspect to this fact; 4.2 million of these uninsured children—about one-fourth of all uninsured children—lived with a parent who had insurance in 1982. This is more than double the number of uninsured children who lived with an insured parent in 1981, just 1 year earlier.

These figures lead me to the second point that I made earlier—that the 1981-82 recession caused a structural change in employers' attitudes toward health insurance which has led many workers to drop insurance for their dependents. This newly uninsured group of people is unlikely to be insured again soon even though the economy is in recovery.

Over the last decade, the rapid escalation of medical costs has forced employers to rethink their attitudes toward health insurance as a fringe benefit. The press has carried a number of stories, particularly about Chrysler, Citicorp, and W. R. Grace & Co., in their efforts to hold the line on their per worker health insurance costs. The costs have doubled for many employers just since 1979. Recessions always cause firms to look closely at all their costs. When sales fall, profits can only be earned if costs are also cut.

Clearly, a cost item that doubles in 4 years is going to set off alarm bells. As a result, all types of employers—and not just large corporations like Chrysler—have begun to cutback on the items covered by their group health insurance contract, and they have been forcing their employees to pay more of the premium; particularly, for family coverage.

It appears that these efforts have caused many employed people to decide not to purchase health insurance, particularly for their dependents. Not only has the number of uninsured children living with an insured parent more than doubled just between 1981 and 1982, but the number of uninsured adults living with an insured spouse went from 2 million to 4.3 million in the same year.

When you stop to think that the cost for family coverage, may be $50 per month, after assuming the employer may pay all of the premium for the worker's coverage—which is not always a correct assumption—and the family may face a $300 deductible, 12 times

50 is $600, plus $300 for the deductible, totals $900, it's not surprising that a family may decide to forego family coverage.

If a family's income is below $18,000, which is roughly two times the poverty level for a family of four, $900 for medical expenses is more than 5 percent of their before tax income.

This brings me to my third point that a wider range of types of health insurance ought to be available. Otherwise, we are likely to see a large segment of the population totally without health insurance, which seems a little like throwing the baby out with the bath water in the efforts to make people more conscious of the cost of their medical care via their health insurance premiums.

The family in my example, for instance, is making a completely rational decision when it drops its family coverage; particularly, when it believes that there is a low probability of a serious and expensive medical problem arising. What this family needs is a low cost insurance policy for catastrophic medical bills.

Why should we care about whether or not a family like my hypothetical family can obtain catastrophic health insurance? First, if they don't have any insurance and they do have a serious medical problem, there is a lot of evidence that they will not seek medical care until the problem is an emergency. Second, when they do seek medical care, they frequently cannot pay for it. Their lack of health insurance places a burden on various Government agencies, and those of us who do have health insurance. Society has to pay for their care via higher taxes or by forgoing other programs so that the Government agencies can be funded, and by paying higher health insurance premiums because the private insurance companies are picking up the cost of charity care in hospitals.

Encouraging a wider range of health insurance policies would also be a positive way of dealing with the diversity of people who lack health insurance. If these policies were largely catastrophic in nature, and therefore had low cost premiums, I think the people would be willing to buy them.

In summation, the proportion of Americans under 65 years old who do not have public or private health insurance coverage has been growing since 1979, reversing the postwar trend. Part of the increase was due to people losing their jobs in the recession, and their health insurance

But part of the increase was also due to employers forcing workers to pay more of the premium for family coverage. This appears to be a structural change in employers' attitudes toward health insurance as a fringe benefit. It seems unlikely that the proportion of Americans who are uninsured is going to return to the 1979 level even as the economy recovers unless something different occurs. More availability of catastrophic types of health insurance especially for the working poor and the working near poor would probably reduce the number of uninsured Americans.

In so doing, the present inequities in ability to pay for serious medical care would be eased.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Dr. Swartz follows:]

Statement of

Katherine Swartz, Ph.D.

Research Associate*
The Urban Institute

before the

Subcommittee on Health
of the
Committee on Finance
U.S. Senate

April 27, 1984

*The views expressed in this statement are those of the author and do not reflect positions of the Urban Institute, its employees, trustees or sponsors.

Thank you for the opportunity to share some of our recent findings concerning the group of Americans who do not have health insurance. I have three major points which I would like to discuss:

- First, the number of Americans under age 65 who do not have health insurance increased by a third between 1979 and 1982, reversing a 30-year trend. In 1979, 28.7 million Americans, or 14 percent of those under age 65, lacked public or private health insurance. By 1982 the number had grown to 38.6 million, or 19 percent of those under age 65.

- Second, the increase is due in large part to the 1981-82 recession. The direct effect of the recession was that many people lost their jobs and thereby lost health insurance for themselves and their dependents. But the recession also had an indirect effect: It caused many firms to look hard at their escalating health insurance costs. Firms are now requiring employees to pay a larger share of the premium as well as more of the direct costs of health care. This has in turn caused workers to look hard at their expense for health insurance, especially for family coverage, which many decided to drop. The increase in the number of uninsured Americans due to this structural change in employers' attitudes towards health insurance will not decline as our economy recovers.

- Third, this part of the recent increase in the number of uninsured people adds a note of urgency to the need for more diverse forms of insurance--in particular, catastrophic health insurance.

I would like to elaborate on each of these points. With respect to the number of uninsured Americans, the recent increase represents a sharp break in post-war trends. Through the 1960's and 70's, the proportion of the under 65 year old population without health insurance steadily declined. Some of the decline was due to government programs, especially Medicaid, for welfare recipients and the disabled. But a greater factor was the increase in the number of employers offering health insurance as a fringe benefit. For employers, health insurance was cheap and it held down the wage base used to calculate Social Security and other payroll taxes. For employees, the employer contributions for health insurance represented untaxed income; and the level of protection against medical bills was obtained at group rates far lower than the cost of comparable individual policies.

By 1979, almost everyone who was a permanent employee of a firm with 100 or more workers had health insurance. Family coverage was also usually purchased through employment--either by the firm in industries where unions were strong, or by the worker--since the large firms could obtain relatively low rates for family coverage.

Who then, in 1979, did not have public or private health insurance coverage? Among the adults, one-third had worked full-time for 40 or more weeks in 1979. The evidence certainly suggests that many uninsured adults worked for small firms that pay low wages and do not offer health insurance as a fringe benefit. Those who were in the labor force were largely in occupations where self-employment or employment in small, low wage paying

firms are the norm rather than the exception

The uninsured in 1979 were not predominantly in the lowest part of the income distribution. Instead, the largest group of them came from families that could be termed working, near poor. Almost half of the uninsured had family incomes between 100 and 300 percent of the poverty level. Only one-fourth had family incomes below the poverty level. The children of such people were also uninsured--almost 40 percent of the uninsured in 1979 were children.

In 1982, the last year for which we have data, the effects of the recession are clearly evident. Only one quarter of the uninsured adults were full-time workers for 40 or more weeks in that year. Adults who said they were looking for work increased from 8 percent in 1979 to 14 percent in 1982. This fall in labor force activity is seen again when we look at the uninsured by family income. While the proportion of the uninsured who had family incomes between 100 and 300 percent of the poverty level was almost the same as in 1979, the proportion who had family incomes below the poverty level increased to 32 percent.

It is important to note that the 1981-82 recession caused many families to lose their health insurance when primary earners lost their jobs. Last summer, much attention was focused on a study which used the 1977 National Medical Care Expenditures Survey (NMCES). Most of the unemployed in the NMCES study did not lose their health insurance coverage. The crucial difference between 1982 and 1977 is that the economy was in recovery in 1977. Those who lost their jobs in 1977 were typically secondary earners in families whose health insurance was provided by the other earner's fringe benefits, or they were employed in the service sector where most often health insurance was not offered as a fringe benefit so they did not have it to lose. The recent

recession hit the durable goods and manufacturing sectors hardest, where health insurance is a widely held benefit. Significantly, only half of the jobs lost in the manufacturing sector in 1981-82 have been regained to date.

In 1982, children accounted again for about 40 percent of the uninsured. This also means that more than 1 out of 5 American children was without public or private health insurance in that year. There is a troublesome aspect to this fact: 4.2 million of these uninsured children--or about one-fourth--lived with a parent who had insurance in 1982. This is more than double the number of uninsured children who lived with an insured parent in 1981.

These figures [illegible] the second point, that the 1981-82 recession caused a structural [illegible] employers' attitudes towards health insurance which has led many workers to drop insurance for their dependents. This newly uninsured group of people is unlikely to be insured again soon even though the economy is in recovery.

Over the last decade, the rapid escalation of medical costs has forced employers to rethink their attitudes towards health insurance as a fringe benefit. The press has carried stories about large corporations such as Chrysler, Citicorp, and W. R. Grace and their efforts to hold the line on their per-worker health insurance costs. The costs have doubled for many companies just since 1979. Recessions always cause firms to look closely at all their costs--when sales fall, profits can only be earned if costs are also cut. Clearly, a cost item that doubles in four years sets off alarm bells. As a result, all types of employers--not just large corporations like Chrysler--have begun to cut back on the items covered by their group health insurance contracts and have been forcing their employees to pay more of the premium, especially for family coverage. It appears that these efforts have caused many employed people to decide not to purchase health insurance,

particularly family coverage. Not only has the number of uninsured children living with an insured parent more than doubled between 1981 and 1982, but the number of uninsured adults living with an insured spouse went from 2 million to 4.3 million over the same time.

When you stop to think that the cost for family coverage (after assuming that the employer pays all of the premium for the worker's coverage) may be $50 per month and the family may face a $300 deductible, the decision to forego family coverage is not as surprising as it might at first appear. In this example, a family would have to have medical costs greater than $900 before its health insurance would have paid for itself. And if the family's income is below $18,000 (roughly 200 percent of the poverty level for a family of four), that $900 is more than 5 percent of the family's before-tax income.

This brings me to my third point, that a wider range of types of health insurance ought to be available. Otherwise, we are likely to see a large segment of the population totally without health insurance--which seems like throwing the baby out with the bathwater in the efforts to make people more conscious of the cost of their medical care via their health insurance premiums.

The family in my example, for instance, is making a rational decision when it drops the family coverage, particularly when it believes that there is a very low probability of a serious and expensive medical problem arising. What this family needs is a low-cost insurance policy for catastrophic medical bills.

Why should we care whether or not people like my hypothetical family can obtain catastrophic health insurance? First, if they do not have any insurance and do have a serious medical problem, there is a lot of evidence that they will not seek medical care until the problem is an emergency. Second,

when they do seek medical care, if they cannot pay for it their lack of health insurance places a burden on various government agencies and those of us who do have health insurance. Society has to pay for their care via higher taxes or by foregoing other programs so that the government agencies can be funded, and by paying higher health insurance premiums because the private insurance companies are picking up the costs of charity care in hospitals.

Encouraging a wider range of health insurance policies would also be a positive way of dealing with the diversity of the people who lack health insurance. The uninsured adults who work for small firms that pay low wages or who are self-employed are another group who could benefit from more availability of health insurance. These workers currently forego health insurance because they could only purchase it at individual rates which are quite expensive. But if groups based on occupations in a given geographical area were formed, the workers should face much lower group rate premiums. They each might then be far more likely to purchase insurance. For example, all hair dressers who work in a county or metropolitan area could form one group, while all taxi cab drivers could be another and all nursery school teachers could be yet another group. In many cases, there are organizations already in place for representing such groups, and the organizations could be approached by insurance companies with group rates. Precedents for group insurance plans exist with construction-related unions and such groups as the American Association of Retired People. If these policies were largely catastrophic in nature, and therefore had low cost premiums, adverse selection should not be a serious problem.

In summation, the proportion of Americans under 65 years old who do not have public or private health insurance coverage has been growing since 1979, reversing the post-war trend. Part of the increase was due to people losing

their jobs and thus their health insurance during the 1981-82 recession. But part of the increase was also due to employers forcing workers to pay more of the premium for health insurance, especially for family coverage. This appears to be a structural change in employers' attitudes toward health insurance as a fringe benefit. Hence, it seems unlikely that the proportion of Americans who are uninsured is going to return to the 1979 level even as the economy recovers. More availability of catastrophic types of health insurance, especially for the working poor and near poor, would probably reduce the number of uninsured Americans. And in so doing, the present inequities in ability to pay for various medical care would be eased.

Thank you very much.

SELECTED INFORMATION ABOUT THE UNINSUREL POPULATION UNDER 65 YEARS OLD IN 1979, 1981, & 1982

	1979	1981	1982
Number of uninsured	28.7 million	36 million	38.6 million
Uninsured/population	14.4%	17.8%	18.9%
Number of uninsured age 18 or under	11.3 million	14.95 million	14.8 million
Number of uninsured kids living with insured parent	--	1.95 million	4.2 million
Number of uninsured adults living with insured spouse	--	2.05 million	4.3 million
Family income relative to the poverty level			
Below poverty level	28%	33%	32%
100% - 199%	29%	31%	30%
200% - 299%	19%	17%	17%
300% - 399%	10%	8%	9%
Above 400% of poverty level	14%	11%	12%
19-64 year olds			
Proportion working	57.0%	53.0%	50.6%
Proportion unemployed	8.3%	12.4%	14.5%

SOURCE: Current Population Surveys of March 1980, 1982, & 1983

Senator DURENBERGER. Let me ask just a couple of questions. In addition to the information that you have in your statement, did you find, for example, regional variation around the country? Did part of your study look at that?

Dr. SWARTZ. No, we didn't look at that. In another study we have looked at the North and East versus the South and West. Health insurance coverage is not as widespread in the South and West. But that really is not part of this study.

Senator DURENBERGER. You talked in the beginning and at the end of your statement about the problems that you perceive in increasing employer cost sharing in health insurance. Then you advocate in your statement that a wider range or wider variety, if you will, of health insurance is needed. Were you able in the course of your analysis to determine what employers were doing in that particular regard? In other words, were they just adding cost sharing to an existing plan—I say that in the singular. I take it that this is true in most cases—or did you see some activity on the part of employers to permit a broader choice of health plans?

Dr. SWARTZ. I have not observed the broader choice of health plans, but what I have observed is that the benefits that are actually covered under the existing contracts have been reduced so that the increase in price of the premium for the contract—just going up from 1982 to 1983—the price did not increase as rapidly as they had anticipated simply because they held down on the benefits that they had been willing to cover in the past.

Senator DURENBERGER. But I take it what you see when you look at employers in most cases one plan per company.

Dr. SWARTZ. Right.

Senator DURENBERGER. And that plan is identical for all employees.

Dr. SWARTZ. Yes.

Senator DURENBERGER. Whether they are the highest paid, the lowest paid, men, women, single, married, young, old, lots of kids, no kids, whatever.

Dr. SWARTZ. I think in general that's true.

Senator DURENBERGER. Isn't that typical of America today?

Dr. SWARTZ. Yes.

Senator DURENBERGER. And that plan probably in most cases is oriented toward a larger number of benefits to cover the largest number of people and those—there's an anticipation of family coverage.

Dr. SWARTZ. I think it depends really on the firm that you are talking about. In a firm that's made up of primarily younger aged people, for example, where children are not part of their family structure, you see a lot more psychiatric benefits that are covered as opposed to a group of employees where there are a lot of children and it is family oriented. There you would see much more in the way of maternity benefits and well child care visits.

Senator DURENBERGER. Do you see some choice between a family plan and what we call a single plan? Or does everybody get the family plan whether they are married or not?

Dr. SWARTZ. No. I think the typical situation is that everyone gets the individual coverage. In many cases, there is cost sharing even for the premium for the individual coverage. But in almost all

cases if a person elects family coverage, that person pays the difference in the premium for the family coverage versus what the firm is willing to pay for the individual coverage. Exceptions to that, of course, are where you have a strong union, and the union has bargained in the past for having family coverage incorporated in what the employer is willing to pay.

But even there, we are seeing pushing back by the large corporations where there are strong unions.

Senator DURENBERGER. Then in the timeframe of your study, the rationale for dropping family coverage was that the cash was not available, so to speak, because during that period of time the money was needed to cover other expenses.

Dr. SWARTZ. Particularly in a recession, I think that families cut back on what they view as being unnecessary expenditures. Just use my example. Fifty dollars a month may be something that they say, gee, do we really want to take that money and put it here or are we going to spend it on the kids' clothing, especially if we feel that primary earner has a 50–50 chance of losing his job.

Senator DURENBERGER. Well, that's what I recall about that period of time, too, especially since I was running for reelection. That there were a whole lot of people who were working who were sure that next week they were going to get their pink slip.

Dr. SWARTZ. Right.

Senator DURENBERGER. And so they weren't necessarily making those decisions on the basis of having to take that dollar and translate it immediately into a bag of groceries, but they were setting it aside in anticipation of the pink slip. Is that part of what you found?

Dr. SWARTZ. I agree completely. I think that's a large part of what is going on. Not only are the firms being forced by a recession to look at those costs, but I think people were so nervous that they also have been forced to look at those costs.

But my argument is that this is really a shift in attitudes. It has made people much more aware of all their different dollar expenditures. And as the dollar expenditures for health insurance have climbed, they are saying, wait a minute, is it really worth the money if we don't think that we are really going to have a heavy medical expenditure this year. And most kids, unless they break a limb or are in a car accident or have some kind of cancer, do not have more than $900 worth of medical bills in a year—even a family of four wouldn't have no more than $900 worth of medical expenditures.

Senator DURENBERGER. Do you have any data in there on employer continuity of coverage? And I think, of the situation in which an employee dies and leaves a widow, widower, children, so forth, uncovered. And, in effect there is no continuity of coverage either because of a dissolution of marriage or termination of employment.

Dr. SWARTZ. I don't have that directly in the form of knowing what happens after someone dies or after they lose their job. But I do know that the incidence of being uninsured, if you are a widow, was somewhere on the order of one-fifth back in 1982. And the surprising thing to me was that when you put that into a model where other characteristics are also included, such as income and whether

or not the person is employed, and size of family, being a widow just disappears as being important for predicting who has health insurance.

I think the primary characteristic that is useful for predicting whether or not someone has health insurance is their income. If a person's income is low, particularly if it's above the poverty level so that he or she isn't eligible for medicaid, such as in this widow case, then the likelihood that that person does not have health insurance is very high.

Senator DURENBERGER. John, do you have a statement or questions?

Senator HEINZ. I have questions, Mr. Chairman. First, I would like to commend you for holding this hearing. I almost wish you had held this hearing before I offered the amendment on health insurance for the unemployed because I think the information that will be presented today will suggest that there is a much greater need and stronger case for Federal support than existed heretofore. At least I hope the chairman of the committee will be convinced of that.

Senator DURENBERGER. I may be by the end of the day.

Senator HEINZ. Maybe we can go to the floor and do something about it. Mr. Chairman, this clearly has been a great problem, particularly on a regional basis. And one of the biggest problems is with the statistics because we tend to believe that they represent a fairly even, nice, gentle average, and that there is such a thing as an average area and an average person and an average family. But many of us who look at their own families know there is nothing average about them.

Let me ask you, Dr. Swartz, in your research did you look at what happens when there are concentrations of uninsured families, concentrations of uninsured children, concentrations of high unemployment?

Dr. SWARTZ. We didn't look directly at where there are high concentrations of unemployment. That was not the direction of the research. But I would argue fairly strongly that I believe this recession did cause a lot of people when they lost their jobs to lose their health insurance. That is quite different than the research that was given a lot of publicity last summer. And I think that that research failed because there has been a structural shift in employers' attitudes towards health insurance that has occurred since the mid-1970's. And the recession was not part of 1977 when that data was collected.

Senator HEINZ. Well, you made two very good points in your testimony. The first is that in the previous recession the 1977 recession, that it was the secondary wage earners who often lost their jobs. The primary wage earner tended to have a more high paying job, and perhaps belonged to a unionized profession where bargaining power resulted in extensive health insurance benefits was able to remain employed.

And the other point you made was the one you just reiterated regarding the shift in employers' cost consciousness regarding health. And as I understand your statistics, the result is that we have 10 million more uninsured people in 1982 versus 1979, and roughly 4 million more children who were uninsured.

Dr. SWARTZ. Right.

Senator HEINZ. That is a very stiff increase. It has been suggested that we could deal with a substantial portion of that problem if we got employers to provide continued health insurance coverage, say, for several months. I gather you would have it a catastrophic package. And that the extension of coverage might take care of as much as 40 percent of the problem.

But we have developed a pattern where people are staying out of work longer and longer because of the structural changes in our economy. The committee on Economic Development, a business group, recommended just a little while ago that we should reorient our unemployment compensation program to take better care of those people who have lost their jobs, but have an unlikely opportunity immediately available to be reemployed. That was the first time I had heard a business group saying what we need longer term unemployment compensation benefits. If business is saying we ought to do that about unemployment compensation, what should we do in the health care area, the health insurance area? Should we have some kind of transitional program that particularly focuses on those who are unemployed for longer than 2 or 3 months, and what should it look like?

Dr. SWARTZ. That's a big question.

Senator HEINZ. It's the one that I want the Senate to answer affirmatively.

Dr. SWARTZ. Well, I think the real problem comes down to, at least in the current stage of debate about the deficit, is how much money do you want the Federal Government and State governments to pay for health insurance for those people who don't have it. Now if you offer health insurance for 5 to 6 months, or whatever number of months you want, for people who did lose their jobs or are going to lose their jobs in the future, along with offering unemployment benefits for a longer period of time, you are not giving them a direct incentive to go out and get a job, and change whatever their skills are. So I have some difficulty with agreeing with that. I don't disagree with the argument that this recession hit a very different group of people than even the 1974-75 recession.

This recession really hit people in your home State, people who work in the durable goods and manufacturing sectors. And I think a lot has to be done in retooling them to get into other kinds of industries, and other types of jobs.

What I am really arguing is that I think there is a lot that can be done through the private sector to get people to get at least some minimal form of health insurance, which is, I think, by and large what most people need for those unexpectedly high bills, which otherwise the rest of us are left paying.

I don't think that they need something which is going to cost, in the form of a premium, $100 to $200 a month which people in the higher and middle incomes, of course, can afford if their employer pays most of it. I think that is unworkable. And things that I have seen where they have offered—for example, Blue Cross in Ohio offered health insurance to people who lost their jobs in Ohio. They were offering them premiums of $100 a month. No one who is unemployed can pay $100 a month for that kind of health insurance. And it's not what they need.

Senator HEINZ. I think in an average kind of world where average people who are unemployed somehow have incomes of 200 percent of the poverty level, that works very well. That's not the actual distribution. And what do you do about the person who has been unemployed for 3 or 6 months and literally has had to break their child's piggybank in order to buy the groceries? Where do they get the money to buy the catastrophic insurance? How do they handle the minor cost of a visit to a doctor's office? How do they handle the minor problem of spending $30 or $40 for some antibiotics?

Dr. SWARTZ. That's a different question.

Senator HEINZ. Because what to you is minor, to them is a catastrophe.

Dr. SWARTZ. No. I'm arguing that if you are talking about catastrophic health insurance, I think you could have it marketed for somewhere between $10 and $25 a month. And if you are talking about people who have lost their jobs, along with the unemployment insurance benefits, I would offer some kind of subsidy to them to buy this catastrophic health insurance because I think that people ought to feel that they have contributed something also to purchasing this health insurance.

What I am arguing is that I think that if in the long run you want them to have incentives to go and either develop different skills, or get another job, that if you give them a lot of cushioning underneath, they are not going to feel the pinch to go get that job quite as rapidly.

Senator HEINZ. Well, that suggests to me a little bit that people enjoy being sick. They don't.

Dr. SWARTZ. No. I'm not arguing that.

Senator HEINZ. And there are plenty of other bills to pay without having to pay health insurance bills, which are for the average family today extraordinarily high especially if they have to pay them on an individual basis because they are not part of a group. If you have ever tried to buy a policy for yourself, you should know that.

Dr. SWARTZ. I have.

Senator HEINZ. Then you know what I'm talking about. And it seems, frankly, ludicrous to me for anyone to argue—that what you need in order to drive people back to work is to make them so poor that they are going to go on welfare. Now that's the problem. The problem is if you want to get somebody to be a nonreentrant into the work force, all you need to do is get them to be poor enough so they do get into the welfare cycle. And it's not that much fun being on welfare.

But if you are on it long enough, it becomes habit. And it will pay your health care bills. It will get you by. My experience with most of the people who have become unemployed, through no fault of their own, who in normal times would be reemployed when the recession was over, is that they want to work; they are seeking work; they are not looking to be a ward of the State, but they have serious problems.

Dr. SWARTZ. Well, that's why I have argued that if you gave the unemployed subsidies for buying catastrophic health insurance,

and when they are employed they pay all of the premium, you leave them in a better psychological state.

Senator HEINZ. Who pays the subsidy?

Dr. SWARTZ. The Federal Government or the State government.

Senator HEINZ. One last question, Mr. Chairman.

In all of these statistics here we focused, and I think appropriately so, on the unemployed, their families, their children. What do we know about lack of health care coverage for older Americans aged 62 through 64? There are a lot of people who take early retirement. Indeed, two-thirds of Americans at least up until very recently—it is probably a year or two out of date now—retired and claimed social security benefits prior to age 65. Medicare eligibility doesn't begin at that age until the first day of the month in which you turn 65. Now we are about to change that on the Senate floor and make it the first day of the next month.

What do we know about the people who retire at age 62 or 63 or before their 65th birthday? And what is their health insurance status? How do they make out?

Dr. SWARTZ. First of all I should say that that is not an area of my own expertise.

Senator HEINZ. Well, then maybe I shouldn't ask. I don't want to ask you to get into an area that you don't know.

Dr. SWARTZ. I can just observe as you have that there are a lot of people who are like that.

Senator HEINZ. Any observations you have, I would appreciate.

Dr. SWARTZ. I think the first observation that I would make is that if you said to me, describe someone who does not have health insurance, I would give three types of people. One is a person like my babysitter who earns an income that is near poor but cannot see that it is worth her money to pay $120 a month for some form of family coverage. The second type is someone who is in their early twenties and doesn't have coverage through their parents' policies, and again doesn't see that there is a risk coming down the road that they might want to have health insurance for. And the third major type is someone who takes early retirement anywhere between ages 59 and 64, who for whatever reason says I'm quitting early and doesn't think about the ramifications of that decision, and does not get to continue coverage through their former employer.

Those are the three main bodies, if you want to think of them that way, or type of people who don't have health insurance. And they all have incomes in the near poor range.

Senator HEINZ. In your statement you didn't mention that last group. Is that because their problem is not particularly serious?

Dr. SWARTZ. No, I didn't mention them because you can predict whether or not someone has health insurance by and large on the basis of their income. And if their income is near poor, that's going to tell you that the likelihood that they have health insurance is below 50 percent. And then the next thing is, well, you want to flesh them out a little bit. And I would give you those three examples of age and family characteristics.

Senator HEINZ. Mr. Chairman, thank you very much.

Senator DURENBERGER. Thank you very much.

Dr. Swartz, thank you very much. We appreciate your testimony.

Our next witnesses are a panel consisting of Patricia Butler, staff director of the Colorado Task Force on the Medically Indigent, Boulder, Colo., on behalf of the National Governors' Association: Alice Kitchen, project coordinator of the Kansas Women's Equity Action League in Shawnee Mission, Kans.: and the Honorable Harvey Sloane, the mayor of Louisville, Ky., on behalf of the U.S. Conference of Mayors. Harvey, welcome. It's a pleasure to have you here today. And it's a pleasure to have all of you as witnesses.

You all are here because you have a special expertise in a special part of the country. And you also have the foresight in your communities to be participating in an effort that we are just starting to commence at the Federal level. So on behalf of the subcommittee and the full committee let me express my appreciation to your communities and the various individuals involved, the Governors and mayors, the county supervisors, and so forth, who committed themselves across the country, and particularly in your three areas, to doing something about the problem we have been aware of for a long time but have neglected much too long.

We will start with the chairman's indication that all of your statements will be made a part of the record. You may read them, summarize them or whatever.

We will start with Pat Butler.

STATEMENT OF MS. PATRICIA BUTLER, STAFF DIRECTOR, COLORADO TASK FORCE ON THE MEDICALLY INDIGENT, BOULDER, COLO., ON BEHALF OF HON. RICHARD D. LAMM, GOVERNOR OF THE STATE OF COLORADO, CHAIRMAN OF THE NATIONAL GOVERNORS' ASSOCIATION COMMITTEE ON HUMAN RESOURCES

Ms. BUTLER. Thank you, Mr. Chairman. I will make a brief presentation out of my statement.

I have also submitted to the staff copies of our three volume study. I hope that if you need more copies, we can make those available.

During 1983, I was privileged to direct a research project for a task force that was convened by the Piton Foundation in Denver to examine the issue of Colorado's medically indigent. We defined this population as persons who are unable to afford needed medical care because of poverty, lack of insurance or inadequate health insurance. Obviously, this definition can include middle-class families with particularly high cost illnesses, especially if they are uninsured.

But our research focused on the poor because we know that as a group they have worse health and greater problems of access to health care. In 1983, we undertook about 12 different research activities, the largest being a statewide inperson sample survey of the poor and near poor in Colorado. And we defined that population as all those persons under 150 percent of the poverty line.

We were trying to find out their health care needs, their health care use, their insurance status. This morning, I would like to share with you the major findings of that particular part of our study.

We found that in Colorado over one-third of the poor are without insurance. By insurance, we mean both the public programs of

medicare and medicaid as well as private coverage. As you know, medicaid covers somewhat fewer than 50 percent of the people under the poverty line. We learned in Colorado that it only covers about 25 percent of the population we surveyed, which is under 150 percent of poverty. That's because of low welfare levels, and also because of the categorical limitations that leave two parent families and individuals out of medicaid.

We found that 40 percent of our uninsured poor population are children under 18. That's consistent with the findings that Ms. Schwartz shared with you a few minutes ago. To me, the most surprising thing we learned was that almost half of the working poor are uninsured, considering that 85 to 90 percent of the working Americans of all income levels receive insurance through the workplace. I was quite struck by our finding that only 54 percent of our working poor population and about 40 percent of our poor population are insured. That seems to me to raise some questions about access to insurance coverage, in addition to its affordability.

We compared the poor with insurance to those without insurance because we were particularly concerned with the uninsured poor, and wanted to determine whether they have a problem of access to care in Colorado. And we learned that they do.

In spite of the fact that the uninsured and the insured poor groups have similar health status, we found that the uninsured are only one-half as likely to have medical visits or hospital admissions as the insured poor. They are also less likely to have a usual source of care from which they can seek needed routine services.

When we looked at the uninsured poor who are sick, we found that they are two-thirds as likely to see physicians when they need to as are the insured poor who are sick.

Particularly at risk are pregnant women and children for whom health care is demonstrably cost effective. The recommendations that we have made to our State legislature, which I am not going to go into this morning but are described in this study I have submitted to you, emphasize targeting pregnant women and children.

We also surveyed physicians and hospitals in the State, and found that many physicians and hospitals in Colorado do provide free or below cost care to the poor, although the contributions vary widely geographically and according to specialty.

But we believe that with the changes in third party payment policies that have begun with medicare and we think are going to continue through private insurance and medicaid, that these providers are going to be less able to render charity care in the future. We therefore think that the problem of access and payment for care for the poor and near poor is only going to become more severe.

One area of research that I don't think we were unfortunately unable to examine very well, and it does need substantial further examination, is the adequacy of current coverage. When we asked whether people were insured or not, we were unable to find out just how comprehensive their coverage is. We do know that among the working people in the State with somewhat higher incomes, that insurance was fairly comprehensive at least last year. I think that there may be changes in employer policies regarding adequacy of coverage, as Ms. Swartz indicated in her testimony.

But we really don't know about the adequacy of coverage for the poor. And I think that we can surmise that at least some people who believe that they have health insurance actually have inadequate protection, such as those hospital indemnity policies that pay $10 a day. As much as this area needs examination, we were unable to develop adequate information on this issue.

There are two important points that the subcommittee should draw from the Colorado study. The first is that although I would not suggest that Colorado is necessarily representative of the Nation with respect to its distribution of the poor and uninsured, our findings do confirm the national data that the poor are much more likely to be uninsured by either public or private programs, and that there is a considerable disparity in access to health care between the insured and the uninsured poor. And I'm sure that those findings, since those have been drawn from national data, at the Federal level, would also be true in other States. Colorado simply exemplifies the dimension of the problem.

My second point is the importance of accurate data for policymakers. As far as I can tell, our State survey is unique. We think that it's a model of comprehensive and methodologically sound data collection. It was done very carefully. We feel quite confident in the statistics that we have developed.

Other States have not attempted this kind of data collection, partly because it's very expensive. The Piton Foundation was quite generous in supporting it. But I do know that other States are interested in this problem. I don't think that the national data that have been developed so far can provide a State-by-State picture because the size of samples are inadequate to draw conclusions about individual States.

Since I think the responsibility for health care for the uninsured poor is going to remain primarily a State and local responsibility in the future, I hope that this subcommittee could support national funding for data collection in at least a sample of half a dozen States throughout the country to flush out this picture in various other places, as we have been able to do in Colorado.

Since beginning to work on this project last year, I have been contacted by at least eight different States that are now beginning to look at their programs for the uninsured poor.

Senator DURENBERGER. That's because I told them about it.

Ms. BUTLER. Good.

A number of them are interested in the kind of work that we have been able to do. But they have been unable to attempt this particularly ambitious research approach. Obviously, the reason that they are interested is a combination of economic realities. The decline in Federal health care funds, the recession, and continuing double digit medical care inflation makes health care less affordable to consumers and makes it more difficult for governments and private providers to render such care.

I'm very pleased that the subcommittee is interested in helping State and local governments wrestle with this complicated and thorny issue. And I will be happy to share our research, our policy deliberations and our recommendations with you.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Ms. Butler follows:]

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COLORADO TASK FORCE
ON THE
MEDICALLY INDIGENT

TESTIMONY OF PATRICIA A. BUTLER,
STAFF DIRECTOR, COLORADO TASK FORCE ON THE MEDICALLY INDIGENT

SENATE FINANCE COMMITTEE HEALTH SUBCOMMITTEE

APRIL 27, 1984

I appreciate the opportunity to speak at the Subcommittee's April 27 hearing on the scope of the medically indigent problem throughout the United States. Your Subcommittee's interest is timely, since over the last year, many states have begun to examine the ways in which health care for the uninsured poor is financed and delivered. I spent 1983 directing a study on this issue in Colorado for the Colorado Task Force on the Medically Indigent, supported by the Piton Foundation in Denver. Our research provides a comprehensive picture of the uninsured poor in Colorado, their health care needs, providers of care to them, and the manner in which their care is currently financed. This information is the most complete currently available in any state on this "hidden" population. Other states' experience may differ, but Colorado's data suggest the dimensions of the problem nationwide and should be helpful to federal as well as state policy makers. I have submitted the 3 volumes of our report for the subcommittee's information. My testimony briefly summarizes our findings about Colorado's medically indigent and compares Colorado's experience with national data. The report includes detailed recommendations to the Colorado state legislature for addressing the problems that the Task Force identified. We would be pleased to discuss those at the future subcommittee hearings on solutions to the needs of the uninsured poor.

A. THE MEDICALLY INDIGENT PROBLEM

The Colorado Task Force defined the term "medically indigent" as "persons unable to afford needed health care because of poverty, lack of insurance, or inadequate insurance." This population includes middle income persons, who may be devastated by a catastrophic illness, such as the birth of a premature infant, especially if they are uninsured or if their insurance coverage is minimal. But our research focussed on the poor because we know that as a group, they have worse health and greater difficulty in obtaining access to needed health care.(1) Despite considerable improvement due to publicly funded programs,

access and health status of the poor throughout the United States continue to lag behind those of higher income groups. Rates of infant mortality, chronic conditions, and disability days are much higher for the poor, while their life expectancies are shorter. We examined most closely the uninsured poor, deemed to be at the greatest risk of medical indigency.

The medically indigent are a problem for state and local government for several reasons. As your Subcommittee well knows, the Medicaid program does not cover many of the poor. Because of Medicaid's categorical requirements and its welfare-related income limits, it has been estimated to cover fewer than half the persons under the federal poverty line. State and local governments have provided health care to these poor who fall between the cracks, but such programs vary tremendously around the country and have been strained in recent years due to: 1) the recession, which increased the numbers of poor while limiting governments' ability to raise revenue; 2) the declines in federally funded poverty health care programs, often designed to serve this population; and 3) the continuing medical care inflation, which makes health care increasingly unaffordable to consumers while decreasing governments' and providers' ability to absorb costs of charity care. Public hospitals are especially squeezed by tight budgets and increased demand for service.

State and local health care program for the uninsured poor raise several problems. Our research has shown that in most states these programs are a fragmented patchwork; their financing burdens are unevenly distributed among providers and among local governments; and care is often not provided in cost-effective settings or at appropriate, early times. Furthermore, since hospitals that do provide charity care must finance it primarily by raising charges to insurers and private patients, their generosity places them at a competitive disadvantage with those hospitals rendering little or no uncompensated care.

B. WHO ARE THE POOR AND UNINSURED?

For purposes of our discussion, "insurance" includes both public coverage, such as Medicare and Medicaid, and private insurance, provided by Blue Cross or commercial carriers. Nationally about 10% to 12% of all Americans lacked health insurance in 1977.(2) In 1982 about 20% of poor adults were uninsured compared to 5% of higher income adults.(3) In Colorado we surveyed the state's poor and near poor at or below 150% of the poverty line, which constitutes about 20% of the total state population. We learned that in 1983 36% of the poor adults and 38% of all the poor were uninsured at the time of the interview.(4)

Insurance status changes over the course of a year. In 1977 nationally 8% of the total population were always uninsured, while about 7% more were insured part of the year. That is, 15% were uninsured for at least part of the year. Among Colorado's poor, 29% were uninsured during all of the previous year, and 16%

more were insured during part of that year, a total of 46% uninsured part of the year. It is often suggested that the uninsured poor are a fluid group that constantly changes and would be difficult to care for through, for instance, organized providers. Yet these data show that there is a relatively stable and routinely uninsured population.

Insurance status is important because the uninsured poor use fewer health services than the insured poor and have the greatest problems in obtaining access to the health care delivery system, despite similar health status. Colorado's statewide health survey of the poor confirmed these general national findings. We learned that the uninsured poor are only about half as likely to have physician visits or hospital admissions as the insured poor, despite similar health status. The uninsured poor who have experienced one of a series of illnesses or disability conditions reported being less able to see physicians when they feel they need to do so. And the uninsured poor are less likely to have a "usual source of health care" than the insured poor.(5)

Examining the characteristics of the uninsured poor revealed both predictable and unexpected results. Blacks and Hispanics are more likely than Whites to be uninsured. Persons in farm or blue collar jobs are more likely to be uninsured than those in service or white collar jobs. Because of Medicare, less than 2.5% of the elderly lack insurance (although it may not cover all their needs). But over 40% of the uninsured are children under 18 and another 14% are persons aged 19 to 24. A most surprising finding was the extent to which the working poor are not insured.(6) About 40% of the poor are employed, but only 54% of them are insured. Thus, while 85% to 90% of working Americans receive their insurance through their workplaces,(7) only about half of Colorado's working poor do so. This may not represent overall national experience among the poor, since colorado has relatively more small and non-union employers than many other states.

We were unable to learn much about the adequacy of the private insurance that the poor carry. We know that it is not always sufficient to protect them against costly illness. While a mediocre insurance policy may provide access to the health system, it will leave the subscriber with out-of-pocket costs that they cannot afford, which become bad debt for providers.

About 86% of persons above 150% of poverty in the state are insured. We looked briefly at the adequacy of insurance among the state's working population covered by large insurance carriers. Tested against a standard of adequate benefits and out-of-pocket cost sharing, we determined that 80% of the carriers that insure over 1/3 of the state's residents protect them against catastrophic medical bills.(8) But some state residents do experience such high cost illness: 1981 state income tax records revealed that about 2% of all taxpaying households had medical bills exceeding 25% of their incomes; moderate and lower income taxpaying families reported more such catastrophic medical

costs than very high or very low income families.(9)

C. PROVIDERS OF CARE TO THE UNINSURED POOR

A survey of just under 3600 office-based physicians in the state showed that about 3/4 of them reported providing some free or discounted care to patients in 1982 (excluding bad debts, courtesy care, or contractual allowances). This result coincides with our survey finding that over 60% of the state's poor routinely seeks its care from physicians' offices. Over half of the responding physicians reported seeing between 1 and 5 percent of their patients for no charge. Forty percent reported seeing an additional 1 to 5 percent at a reduced rate.(10)

Charity care among the state's 82 acute general hospitals varied widely. About 1/3 of them have Hill-Burton obligations, most of which expire over the coming decade. 25 hospitals participate in the state's "Medically Indigent" program, which partially pays for the poor. 37 hospitals, including some of the Hill-Burton and Medically Indigent Program providers, participate in a state-funded program paying for low risk deliveries for poor women in community, non-Denver hospitals.

We determined that overall the state's hospitals have been doing reasonably well financially in recent years. But many rural hospitals are small, subject to wide variations in occupancy and debt collection, and not financially secure. Deductions for bad debt plus charity care averaged 6.6% of gross patient revenues for Colorado hospitals in 1982. The greatest proportion of this charity care was provided by the state's two large public institutions, Denver General and University of Colorado Hospital. Excluding them, our analyses showed that small, rural hospitals had greater charity care and bad debt burdens than their larger urban counterparts.(11)

D. FINANCING AND DELIVERY OF CARE TO THE UNINSURED POOR

It is very difficult to categorize the numerous approaches that state and local governments use in financing their programs of care to the medically indigent. Many, such as Nebraska and Washington, provide eligibility for medical care through their General Assistance welfare programs. Others, such as counties in California and Texas, operate public hospitals or clinics. Others offer categorical programs for certain diseases or conditions, such as maternity care (Connecticut), dentures (Maine), or emergency services (Pennsylvania). Maine, Alaska, and Rhode Island have catastrophic health insurance programs. Other states support the charity care of hospitals either through a hospital rate- or revenue-setting system (Maryland, Massachusetts, New Jersey, New York) or through direct subsidies (Colorado).

I will briefly describe Colorado's program. For ten years the state has been appropriating a modest sum (currently about $35 million) as partial support for hospital charity care.

25 hospitals participate in 1984. But 90% of the funds are designated by statute to the two large public hospitals located in Denver, so very little money is available for the outlying hospitals, which in 1983 received 30% of their costs of caring for this population. Costs not paid by the state are shifted to other payers. In 1983 the program served about 75,000 people, primarily children and women of childbearing age. Notable problems with te state's Medically Indigent Program are: its orientation toward hospital care (2 clinics participate, but physicians cannot do so), its emphasis on emergency and acute care rather than preventive care, its low reimbursement rate, and its disproportionate funding to the two Denver public hospitals.

E. CONCLUSION

In general, the Task Force found that the uninsured poor, especially those in poor health, have less access to health care than the insured poor or their higher income counterparts. Furthermore, changes in public and private reimbursement for health care is diminishing the capacity of providers to render free or discounted care to the medically indigent. Public hospitals are particularly hard hit by budget limits and increased demand for services.

Health care financing in the United States is in transition, and its changes will profoundly affect availability of health care for the poor. Because health care costs continue to rise faster than general inflation all levels of government are attempting to reduce their health care costs. D.R.G.'s, for instance, will limit revenues to some hospitals previously available for charity care and may become the reimbursement model for insurers and Medicaid programs, further limiting the possibility to shift costs of uncompensated care to other payers.

Concern over the costs of new sophisticated life-saving and life-prolonging technology will raise the issue of rationing health care and will certainly have an impact on the poor. While the Task Force could not predict the future, it acknowledged the importance of continuing to examine the problem of medical indigency during the coming, volatile years.

Most state and local governments are reluctant to raise taxes to support health care for the indigent. The Colorado legislature has resisted the Task Force's recommendations to increase state spending on these programs, saying that health care costs are out of control and that the state should not spend more dollars on an inefficient, voracious system. State and local governments must decide who is responsible to finance and deliver care to the poor in the most cost effective manner. There will be an ongoing need to balance often competing interests of the health care needs of the poor, burdens on health care providers, limited public dollars, and the value that society places on a healthy, productive population.

FOOTNOTES

1. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care, Vol. 1 at 59-79 (1983); Robert Wood Johnson Foundation, Updated Report on Access to Health Care for the American People (1983); B. Starfield, "Family Income, Ill Health, and Medical Care of U.S. Children," 4 J. Public Health Policy 224 (1983); Davis, K. and Rowland, D., "Uninsured and Underserved: Inequities in Health Care in the U.S." 61 Milbank M. Fund Q. 149 (1983).

2. G. Wilensky, D. Walden, and J. Kasper, The Uninsured and their Use of Health Services (National Center for Health Services Research, August 1981).

3. Robert Wood Johnson Foundation, Updated Report, supra note 1.

4. Colorado Task Force on the Medically Indigent, Colorado's Sick and Uninsured: We Can Do Better Volumes 1 and 2.

5. Ibid.

6. Ibid.

7. A. Monheit, M. Hagan, M. Berk, and G. Wilensky, Unemployment, Health Insurance, and Medical Care Utilization (National Center for Health Services Research, November 1983).

8. "Survey of Insurance Coverage" in Colorado Task Force on the Medically Indigent, Colorado's Sick and Uninsured: Background Resource Papers Vol. 3 p. 117.

9. "Catastrophic Illness in Colorado", Ibid. p. 109.

10. "Colorado Physician Survey", Ibid., p. 145.

11. "Financial Status of Colorado Hospitals: An Analysis of Operating Margins and Free Care/Bad Debt Burdens", Ibid. p. 87.

35-184 O—84——3

Senator DURENBERGER. Before we go to the next witness I want to make an observation in case anybody is listening outside of this room. It may or may not be unique in Colorado, but at least you have a Governor who cares. That's my personal observation. You have bipartisan legislative leadership that cares about the issue. You have an employer and a philanthropic community that is concerned about the issue and willing to invest time, staff expertise and money into doing something about it. And, obviously, you have a population that is concerned.

Now I would assume we ought to be able to say that about every one of the 50 States, that every Governor cares, and, hopefully, every legislator does. And we keep reforming the foundation tax advantages so there ought to be plenty of foundation money around. And I hope that more of the States are coming to see what you are doing because I think you have gotten a good start on the project. It is not impossible. It doesn't have to be unique to Colorado. Anybody can do it if they care enough. Would you agree with that?

Ms. BUTLER. Absolutely. I must say however, that so far we have been unsuccessful in getting the legislature to adopt any of the recommendations that the task force has come up with. But we also haven't given up on that yet.

Senator DURENBERGER. Are they still participating in the task force?

Ms. BUTLER. Well, the task force technically terminated existence when the report was published in February. Those particular legislators were not as interested as I think other members of the legislature are.

Senator DURENBERGER. I'm glad you elaborated on that.

Alice Kitchen from Shawnee Mission, Kans. Thank you for being here.

STATEMENT OF MS. ALICE KITCHEN, PROJECT COORDINATOR, KANSAS WOMEN'S EQUITY ACTION LEAGUE, SHAWNEE MISSION, KANS.

Ms. KITCHEN. Thank you for inviting me to appear before the committee today. I am the project coordinator for the Kansas Women's Equity Action League. Our project is an outgrowth of 2 years of our work with women and our legislature to improve the circumstances for mid-life women who are without medical insurance. And I'm pleased to tell you that on April 6 the Governor did sign into law a bill that mandates continuation of benefits for 6 months for a former dependent, and their children.

Our efforts have been combined closely with the National Older Women's League, the National Women's Equity Action League, and the Kansas Department on Aging.

My purpose here today is to share with you some data that we have and some perspectives that we have concluded about these problems. Essentially, we are talking about two things—access and affordability.

Our target group you know. And they are mid-life women between 45 and 65 years of age. And we look primarily at those that were former dependents.

The characteristics of our particular group that we studied were that they were not in the work force, or if they did work part time, they were in low paying jobs that offered no health benefits.

They were primarily women who were dependent on their worker spouse for access to medical coverage. And many of them were widows who may have not known about their conversion rights or if they knew about them, they did not exercise them in time or know about them within the 31-day limitation to seek and find comparable coverage at an affordable rate.

The most significantly hurt group is that of divorced women. And as their numbers are increasing so are their problems. And they have great difficulty in getting medical insurance since the courts do not have jurisdiction over the settlement regarding health care. That is often left out and not provided for.

Essentially our approach has been to look at the data and related indicators and to ask Kansas women to write to us about their personal experiences. To give you a picture of the group, we have included several graphs that you have for your review. And next I have indicated in the testimony the scope of the problems from the total population and the percent of those that are uninsured based on 1981 data so you know that it is understated.

From there we narrowed the information and reviewed the data, and we found something that I think is very startling and significant for you. We found that one in five women in Kansas aged 45 to 65 is faced with the problem of no medical insurance. And then I have broken that down for how that relates to the total population in the raw numbers, and then compared California, and given you the national percent and raw numbers about medical insurance.

In addition to the data, we asked the women about their circumstances and they told us some things. And the common thread that we found in their stories to us in their letters were that most of them were under $10,000 in their annual income; they were generally between 55 and 65 years or age; and although they had experienced a change in marital status, it wasn't recent. They were still experiencing the consequences of that change. And were having difficulty in getting coverage or had no coverage at all.

Next we found that the main problem they experienced was cost. I know that's not surprising.

The next problem in the ranking was the reduction of benefits. And then after that, we found that timely notification was an area of considerable trouble and concern for them.

And although we didn't ask them to tell us, many of them did indicate that they currently had no medical insurance coverage. Again we looked at the date and we looked for long-term implications. We took the group and we did a forecast of the population as it would go into the year 2010. And you will note that in the year 1990 there will be a decrease in this population group. And then by the year 2000 and 2010, there will be an alarmingly large number of people in this category who could experience this problem.

With all this said, we listed the problems and some of the reasons behind the problems. We identified cost, access, preexisting conditions, age ratings, age differential, part-time employment, insurer, bankruptcy, employer termination of group plan, medicare, and self insuring as those areas that do cause the difficulties that

this group experiences. I won't go into great detail, but I think that the cost—I have explained how different States have some provisions to handle this. They are conversion and continuation. And given that not all States have these benefits, you can see that there is no basic standard that you can expect across the country that will take care of this problem.

Access—former dependents may not find out about their conversion rights. Some of them told us they were confused and were apologetic because they didn't know. And if you have ever read an insurance policy, you would understand that it is hard for the average member to understand what they are really saying.

Notification doesn't always happen either, even though it was mandated in previous legislation. It does not always happen. And if it doesn't happen in a timely manner, you only have 31 days, it's very difficult to expect that they could get it.

So this leaves the dependent without adequate time during a very stressful period to make complicated decisions. We are talking about people experiencing divorce, death, retirement of a spouse, disablement of a spouse. Those are the kind of things that we are expecting people to make good decisions and go out and find insurance. And I think you can appreciate the difficulty there.

The next item is preexisting conditions. And the difficulty there is, the insurers feel that this particular group, when they changed their status with the group, all of a sudden become a high risk group. Now mind you, these people have been a part of the group for a long time, but all of a sudden because of their change in marital status, they become high risk. And this phenomenon is called in the insurance industry adverse selection. However, I suggest to you that the insurance companies own actuarial tables do not support this. And I have included an actuarial table that I have circled mid-life women's rates, and you take the same information and go across the chart, and you will see that mid-life men rates are higher.

Next is age rating. Most insurance companies in Kansas except Blue Cross/Blue Shield age rate. This practice causes the older citizens to pay higher premiums—medicare supplement—at a point in their life when their income is shrinking.

Another one—age differential, which is not something we can do a lot about. That refers to the practice of men marrying women younger than themselves. And that could result in no medical coverage for the spouse when the worker spouse retires and becomes eligible for medicare. And this doesn't even deal with the problem that was referred to earlier of the worker who retires early.

Part-time employment. I think that is self-evident that dependents as well as single workers in part-time, low-paying jobs usually do not have access to health care.

Insurer bankruptcy and employer termination of group plans. A number of people told us that this is why they had no coverage. They felt helpless. They felt that they were caught in circumstances they could do little about.

Next is medicare age. This is currently not a problem. However, if the recommendation of the Social Security Advisory Council is implemented, and the age is raised from 65 to 68, we could see a further widening of the gap of those without medical insurance. So

I would suggest that that would be something that you would want to look very carefully at.

Next and perhaps the most significant area is self-insuring. The Employee Retirement Income Security Act [ERISA] of 1974 has in its legislation a title that covers employee fringe and health benefits. And this section spells out administrative procedures for fiscal matters, reporting and disclosure practices for self-insured. And because the self-insured medical plans, those that fall under the jurisdiction of ERISA, have minimal standards, and many employers are now choosing for that reason to self-insure, and then they, therefore, escape the scrutiny of State insurance commissioners.

Other reasons that companies do this is that they avoid the State premium tax, and regulations.

Under this regulatory vacuum of ERISA, companies can write plans that do not cover certain medical conditions. And, thereby, exclude coverage that has been deemed necessary and humane by many State insurance commissioners.

Recommendations. From all of those, barriers that effect health care, there are several that I think are within your jurisdiction. Many, although, are not. One of the obstacles that was inadvertently created with the inclusion of the title on health care plans in the ERISA legislation is the one that I think may fit very appropriately in your jurisdiction.

This giant loophole in the regulation of health insurance plans made it more attractive, as I said, for the companies, and it became less expensive for them to self-insure.

This erosion to ERISA also served to allow companies to covertly avoid State premium taxes and regulations. According to a California pension consultant to the California assembly, he estates that 50 percent of health plans today are not under the State regulations.

This suggests that you may want to reexamine this section of ERISA, and you may want to strengthen or add standards, regulations, to this legislation, which will return insurers to a measure of health care protection that was previously achieved by the State and at the State level.

You could, for example, amend ERISA to end the preemption for self-insured or another way you could do it is you could add to the health coverage section of the ERISA standards and regulations, to upgrade the level of protection. This would require probably additional staff for the Department of Labor so that they could adequately monitor and regulate that mandate.

My second recommendation is to study carefully the consequences of change in the medicare age change up to 68. And it is conceivable that making that change would cause more harm done to individuals than it would solve the problems.

In conclusion, women in mid-life years have significant problems, as I have listed in my testimony. These problems are basically access to affordable coverage. These barriers have been further complicated by the ERISA legislation and could be in the future compounded by the change in the medicare age.

Mid-life women, I suggest, are particularly vulnerable for reasons related to their role as wives, mothers, and homemakers. For this group to be excluded from health coverage is unconscionable. In

our medical economy, according to Fran Lenoard of the Older Women's League, no health care coverage means no medical care.

We of the Kansas WEAL project are grateful for your interest and for your exploration of these problems. Your consideration and scrutiny of the barriers will make it possible to develop good, sound social policy in this area.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Ms. Butler follows:]

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Women's Equity Action League

Specialists in Women's Economic Issues

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Elaine Harvey
Hays
Jeanette Livingston
Topeka
Ruth Lyons
Independence
Ila Major
Overland Park
Pat Moore
Wichita
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Garden City

STATEMENT OF THE KANSAS
WOMEN'S EQUITY ACTION LEAGUE

Before the Senate Finance Sub-Committee on Health
Washington, D.C.
April 27, 1984

Senator Durenberger and Committee Members:

Thank you for inviting me to appear before your Committee today. My name is Alice Kitchen, volunteer Project Coordinator for the Kansas Women's Equity Action League. Our project is an outgrowth of two years of work by Kansas women to improve the circumstances for mid-life women who are without medical insurance. Our Steering Committee is made up of women in ten cities from across Kansas. Our efforts have been combined closely with those of the National Older Women's League, the National Women's Equity Action League, the Kansas Department on Aging, and many of our Kansas state legislators.

My purpose here today is to provide you with some data and perspective on the problems. In brief, most of the problems concerning coverage relate to two areas:

- lack of access
- lack of affordable coverage

The target of our efforts is mid-life women, between 45 and 65 years without medical coverage.

Characteristics of this group of women are:

- they are generally not in the work force, or they work part time in low paying jobs that offer no health benefits.
- they are women who depend on their worker spouse for access to medical coverage.
- if they are widows, they may not have known about their conversion rights, or if they knew, did not have time (31 days) to secure individual coverage at a comparable rate.
- if they are divorced, and the number is increasing, they may not have received medical insurance as a part of the divorce settlement.(See attachment A)

Our approach to this issue has been to:

- look at the data and related indicators, and
- ask women to write to us about their experience.

To give you a picture of the group we are talking about, we have included several graphs that illustrate our points. (See attachments A & B)

First, let me give the overview of the total population. According to the 1981 survey completed by the Planning & Evaluation Division of Health & Human Services, the breakdown is as follows:

6.4% have no medical insurance
62.3% have group coverage
10.8% have individual policies
6.5% have Medicaid
14.0% have Medicare or public health services

Then, narrowing this information and reviewing the data from several directions we have been able to estimate the number of women in the mid-life years who have no medical insurance. We found that one in five women in Kansas between 45 and 65 is faced with the problem of no medical insurance. This group represents 19.4% (154,293) of the total population of women in Kansas. Based on the same formula, 19.2% (500,000) women in California fall in this category. Nationally, in all age groups, 21.5 million people are without medical insurance.

In addition to the data, we asked women in these circumstances across Kansas to write and tell us their experiences. We found some common threads. Most of the women:

- had less than $10,000 annual income.
- were between 55 and 65, and although their change in marital status was not recent, they were still experiencing the consequences of no coverage or inadequate coverage.
- found cost to be the main deterrent. This was followed by reduction in benefits and lack of timely notification.
- indicated that they currently are without coverage.

Again we looked at the data to determine if this problem had long term future implications. (See attachment B.) The information tells us that this mid-life group will level off and decrease in 1990. Then, however, we see a significant increase in the year 2000, followed by an alarming jump going into 2010.

Having identified the target group, their characteristics, and the scope of the problem, I would like to comment on the obstacles that prevent this group from acquiring or maintaining coverage. The barriers we have idenitified are:

1. COST. Plans available to former dependents and their children generally are much more expensive than their previous group coverage. In continuation rates the dependent pays the group rate (both the employer and the employee portion), and in conversion rates, the premium is usually double the group rate. (See attachment B.) Individual rates may be less expensive but are often difficult to acquire, do not provide comparable coverage, and may exclude various medical conditions. Only continuation rates provide the same scope of coverage. Usually the other plans have high deductible, high costs, and minimal benefits.
2. ACCESS. Former dependents may or may not find out about their conversion rights. If the state has a continuation or a conversion privilege, there is a time limit. Notification of the former dependents does not always happen or happen in a timely manner. This leaves the dependent without adequate time during a very stressful period to make complicated decisions.
3. PRE-EXISTING CONDITION. Trying to secure health coverage with a pre-existing condition is like sending a youngster to school with chicken pox--they don't want the child in the group. Insurers argue that this adds an additional risk to an already high risk group. This phenomenon is called "adverse selection." However, I suggest to you that the insurance companies' own actuarial tables do not support this concept. (See attachment B.)

4. AGE RATING. Most insurance companies except Blue Cross/Blue Shield in Kansas age rate. This practice causes older citizens to pay higher premiums at a point in their lives when their income is shrinking.
5. AGE DIFFERENTIAL. The practice of men marrying women younger than themselves can result in no medical coverage for the spouse when the worker spouse retires and becomes eligible for Medicare.
6. PART TIME EMPLOYMENT. Dependents as well as single workers employed in part time low paying jobs usually have no access to health benefits.
7. INSURER BANKRUPTCY OR EMPLOYER TERMINATION OF GROUP PLAN. This problem affects all formerly insured members in a critical way. There is little recourse for these members; however, according to the Kansas Insurance Commission office, companies under the jurisdiction of Chapter 11 may eventually pay off the claims they owe.
8. MEDICARE AGE. This is not currently a problem. However, if the recommendation of the Social Security Advisory Council is implemented and the age is raised from 65 to 68, we will see a further widening of the gap for those without medical insurance.
9. SELF INSURING. The Employee Retirement Income Security Act, ERISA, has in its legislation a title that covers employee [illegible]age and health benefits. This section spells out administrative procedures for fiscal matters, reporting and disclosure practices for self-insured plans. Because these self-insured medical plans that fall under the jurisdiction of the ERISA law have minimal standards, many employers are now choosing to self-insure, thereby escaping the scrutiny of the State Insurance Commissioner. Other reasons companies self-insure are to avoid state premium tax and regulations. Under the regulatory vacuum of ERISA, companies can write plans that do not cover certain medical conditions, thereby excluding coverage that has been deemed necessary and humane by many state insurance commissions.

RECOMMENDATIONS:

Many of the barriers to health care that I have mentioned fall under state regulations. The causes of some of these obstacles are, however, within your jurisdiction. One of these obstacles was inadvertently created with the inclusion of the Title on health care plans in the ERISA legislation. This giant loophole in the regulation of health insurance plans made it more attractive and less expensive for companies to self-insure. This erosion to ERISA also served to allow companies to covertly avoid state premiums and regulations. The Pension Plan Consultant to the California Assembly estimates that 50% of the health plans today are not under state regulation. This suggests that you may want to reexamine this section in the ERISA legislation. Strengthening or adding standards and regulations to this legislation will return insurers to a measure of health care protection that was previously achieved at the state level.

My second recommendation is to study carefully the consequences of changing the Medicare age to 68. It is conceivable that the proposed gains will be outweighed by the harm done to individuals by widening the gap till the time they are Medicare-eligible.

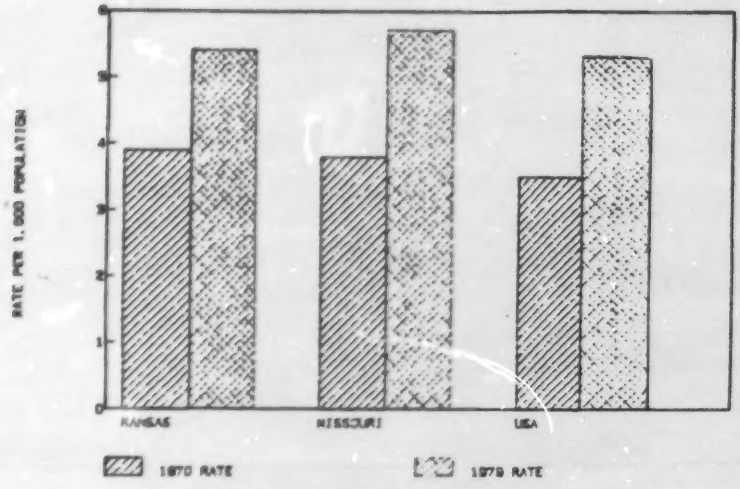
In conclusion, women in their mid-life years have significant problems related to health insurance. These problems are basically...access to affordable coverage. These barriers have been further complicated by the ERISA legislation and could be compounded by changing the Medicare age. Mid-life women are part cularly vulnerable for reasons related to their roles as wives, mothers, and homemakers. For this group to be excluded from health coverage is unconscionable. "In our medical economy", according to Fran Leonard of the Older Women's League, "no health coverage means no medical care."

We of the Kansas WEAL project are grateful for your interest and exploration of these problems. Your consideration and scrutiny of the barriers will make possible the development of good social policy in this area.

4/25/84

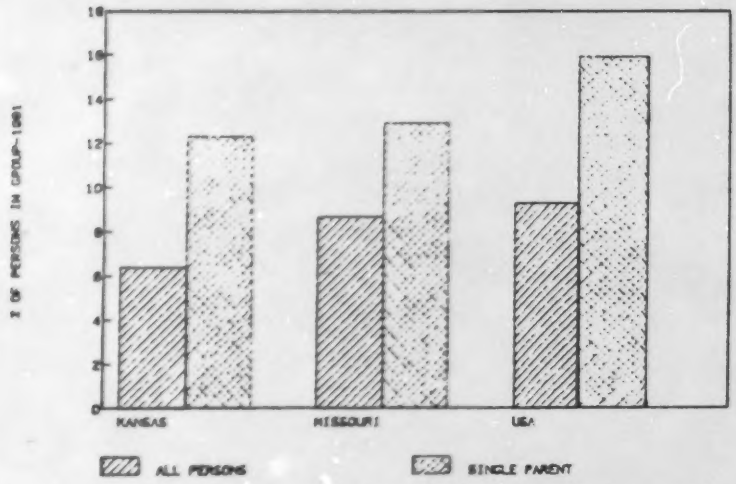
ATTACHMENT A

DIVORCE RATE



1982 Kansas State and Metropolitan Area Data Book
Analysis by Dr. Elaine Tatham, E.T.C. Institute, Olathe, Kansas, April, 1984.

NO HEALTH INSURANCE



1981 Data from Health and Human Services Planning and Evaluation Division
Analysis by Dr. Elaine Tatham, E.T.C. Institute, Olathe, Kansas, April, 1984.

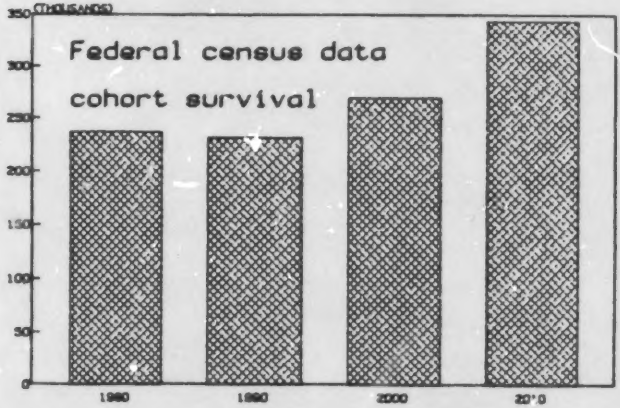
QUARTERLY PREMIUMS TABLE
FOR MAJOR MEDICAL CONVERSION PLANS

ATTACHMENT B

PREMIUM RATE AREA	AGE	MALES $100 Deductible	MALES $500 Deductible	MALES $1,000 Deductible	FEMALES $100 Deductible	FEMALES $500 Deductible	FEMALES $1,000 Deductible
A	20-24	202.67	168.70	147.87	282.94	249.58	228.46
	25-29	202.67	168.70	147.87	377.81	321.26	284.12
	30-34	207.88	174.24	151.58	384.88	326.70	273.42
	35-39	222.14	186.95	161.82	389.49	329.53	279.83
	40-44	262.88	220.52	191.56	402.68	339.41	282.82
	45-49	315.06	264.08	228.71	422.15	354.83	288.97
	50-54	387.63	324.89	281.79	425.68	357.56	288.76
	55-59	484.98	408.28	354.33	443.39	372.98	321.78
	60-64	577.81	483.79	417.57	516.84	434.69	375.72
	Each Child	94.88	78.12	68.03	94.88	78.12	68.03
B	20-24	222.94	188.67	162.66	322.23	274.52	227.11
	25-29	222.94	188.67	162.66	414.71	353.39	290.53
	30-34	227.88	191.66	166.79	423.48	359.37	300.78
	35-39	244.35	205.65	178.08	428.34	381.37	307.82
	40-44	288.14	242.57	210.74	442.95	373.35	321.22
	45-49	346.57	290.49	252.68	464.37	390.31	336.57
	50-54	426.39	357.38	309.47	468.26	393.32	339.64
	55-59	533.48	450.21	385.76	487.73	410.28	353.96
	60-64	635.79	532.07	459.33	568.52	478.16	413.29
	Each Child	104.39	88.93	72.63	104.39	88.93	72.63
C	20-24	243.20	203.64	177.44	351.53	299.47	247.79
	25-29	243.20	203.64	177.44	452.41	385.51	316.94
	30-34	248.51	209.09	181.91	461.98	392.04	328.18
	35-39	266.57	224.34	194.18	467.28	394.22	335.92
	40-44	315.42	264.62	229.90	483.22	407.29	350.42
	45-49	378.07	316.90	275.65	508.58	425.80	367.16
	50-54	465.16	389.87	338.15	510.83	429.07	370.51
	55-59	581.98	491.14	425.20	532.07	447.58	386.14
	60-64	693.49	580.64	501.58	620.21	521.63	450.86
	Each Child	113.83	93.74	79.24	113.83	93.74	79.24
D	20-24	263.47	220.61	192.23	380.82	324.43	268.40
	25-29	263.47	220.61	192.23	490.11	417.64	343.36
	30-34	269.22	226.51	197.07	500.47	424.71	355.45
	35-39	288.78	243.04	210.37	506.22	427.08	363.91
	40-44	341.71	286.68	249.05	523.48	441.23	379.63
	45-49	409.58	343.30	298.62	548.80	461.28	397.76
	50-54	503.92	422.36	366.33	553.40	464.83	401.39
	55-59	630.47	532.08	460.63	576.41	484.87	418.31
	60-64	751.28	629.81	542.84	671.89	565.10	488.44
	Each Child	123.32	101.56	85.84	123.32	101.56	85.84
E	20-24	283.74	237.58	207.02	410.12	349.38	289.04
	25-29	283.74	237.58	207.02	527.81	449.76	369.77
	30-34	289.93	243.94	212.23	538.97	457.36	382.79
	35-39	311.00	261.73	226.55	545.16	459.93	391.90
	40-44	367.99	308.73	268.21	563.75	475.17	408.83
	45-49	441.08	368.71	321.59	591.01	496.76	428.36
	50-54	542.68	454.85	394.51	595.97	500.58	432.26
	55-59	678.97	572.99	496.06	620.75	522.17	450.49
	60-64	809.07	677.18	584.60	723.56	608.57	526.01
	Each Child	132.80	109.37	92.44	132.80	109.37	92.44

MUTUAL OF OMAHA

WOMEN, AGES 45 - 64



STATE OF KANSAS (cohort survival-population forcast of a specific age group)

1980 General Social and Economics Characteristics: Kansas
Analysis by Dr. Elaine Tathan, E.T.C. Institute, Olathe, Kansas April, 1984.

STATEMENT OF HON. HARVEY SLOANE, M.D., MAYOR OF LOUISVILLE, KY., ON BEHALF OF THE U.S. CONFERENCE OF MAYORS, WASHINGTON, D.C.

Senator DURENBERGER. Dr. Sloane, welcome. It's a pleasure to have you here.

Dr. SLOANE. Thank you, Mr. Chairman. On behalf of the Conference of Mayors let me say that we certainly appreciate that you are holding these hearings. We know of your interest in delivering health care to everybody, particularly the medically indigent.

As you know, I'm in my second term as mayor of Louisville. I'm also a physician. I've set up public health clinics in eastern Kentucky and also in Louisville so I'm personally and professionally very much concerned about health care delivery to our economically disadvantaged.

Mayors are in a unique position of representing health interests of consumers, providers, and employers. The health interest of one group of consumers, the economically disadvantaged, are particularly compelling. Who are these people?

We believe they are the uninsured and the underinsured, as the previous speakers have mentioned. According to a study on the subject by the Robert Wood Johnson Foundation, it's made up of 21 million adults and 7 million children. Included are people who are on medicaid, for whom coverage is incomplete the elderly women and children and the disabled; the working poor who may not qualify for medicaid but cannot afford private insurance and self-payment for care; and a new category that you have talked about, and those who have recently lost their jobs and health benefits attached to those jobs—the new poor.

Let me just discuss new poor a moment. In cities across the country, we are seeing people who are losing their jobs, exhausting their unemployment benefits, and losing their homes. These people are coming to health and human service agencies for the first time. And it's difficult for many people to do so.

Human service agencies in Evanston, Ill., reported to the Conference of Mayors that they have been presented with serious problems of psychological distress, alcoholism, and even violent behavior among those unable to cope with having to seek help from local agencies.

Many many have no home, and haven't had a home for a long while. These are the homeless, people referred to as bums, bag ladies, derelicts. In Louisville, street people have increased fourfold in the last 3 years. I've been visiting missions and shelters over the last months and have gotten this information personally.

Some of the long-term homeless are deinstitutionalized people. In 1965, there were approximately 560,000 mentally ill persons in public psychiatric hospitals in this country. Today, because of Federal and State action, and court decision, the patient population has shrunk to about 125,000. We estimate that there are currently over 1 million chronically mental ill people living in communities, many of whom are homeless requiring a variety of health and social services.

All of the people we have been speaking about—the uninsured and the underinsured—come to us, to the cities, for health care that, in some measure, they cannot afford.

Though we may not be able to afford to provide it, we must and we do.

A community in your home State, Senator, Bloomington, a small community with an annual budget of $1 million, in 1980 gave a full 10 percent of their total budget, $100,000 of local tax money to provide health services to low-income people.

Although there is a compelling need for more funding for health services, this must be coupled with some system design changes of the present method of health delivery. And in Louisville and other cities, let me share some of the things that are going on.

As you know, in Louisville we have had a very significant agreement between a private hospital corporation, Humana, with the university hospital to operate the hospital, which has been historically providing indigent care to Louisville. As part of the unique agreement between the city, county, and State governments and the University of Louisville, the Humana Corp. is now providing unlimited health care to indigents at the Humana Hospital University, which is also the university teaching hospital.

In the first year of the agreement, the private corporation extended care valued at $6 million beyond contributions of the three governments. They expect to see that reduced in the future by alternate delivery systems of outpatient care.

Through this involvement of the private sector in indigent care, a greater level of health care has been brought to the poor who need it most. This has been very timely since the cost of hospital care has increased 61 percent the past 3 years, while the Government funding contribution has only been able to increase 41 percent.

Second, another local initiative designed to provide greater health care through the partnership of the private sector is ACCESS, a primary health care center affilitated with the university hospital. The center is treating 120 patients a day, many of whom are being spared a costly visit to the hospital by early outpatient care. More of these centers will be created.

Just this last week in Kentucky, the Kentucky Medical Society and the Kentucky Hospital Association endorsed a set of proposals urging more voluntary care for the indigent. In all, there are 26 proposals developed by a citizen's committee, Kentucky Held Access Committee, which could lead to greater health care for the needy at little or not cost to the Government.

One of the proposals endorsed by the private associations would be the establishment of a hotline to link patients who can't afford medical care with physicians and hospitals participating in the program.

Another approach, the medicaid capitation system, offers an experimental capitation program for AFDC recipients and their families. With medicaid capitation, patients are assigned to one physician who is responsible for the care of the patient for a predetermined amount of money.

Two service areas that need special attention are outpatient care and pharmaceutical supplies. There is no centralized approach to

improving these areas, which are critical to an individual's well-being. Local churches are trying to fill the need of providing for drugs to needy patients, but this demand has overwhelmed their resources.

Cities are not simply appealing for Federal funds for health care with outstretched hands. We are launching our own initiatives, often with local funds. But these initiatives are not enough to offset increasing demands for health care. An example of the increased demand for services is demonstrated by the increased amount of uncompensated care given by hospitals in Kentucky. These hospitals in 1979 delivered $123 million in uncompensated health care, which increased to $231 million in 1982. That's a 55-percent increase in just 3 years.

Where do we go from here? First, please, no further reduction in health service dollars. Under the guise of reducing the Nation's health spending, don't cut Federal dollars and shift costs to public facilities and consumers, the latter who may well not receive needed health care.

Second, new strategies must be developed to slow the rise in health care costs. One, home health care should be available to all individuals in need in order to effect early discharge from more costly hospitalization. Two, systematized outpatient service delivery models should be developed that have as their major impetus preventive health and primary care services. Three, the new diagnostic related grouping system, for example, is acceptable if it is applied across the board with a higher financial remuneration for public facilities that are providers of the last resort, especially for the chronically ill. Four, pursue the theory of competition, such as prepaid group practice, HMO's, medical foundations, medicaid capitation, and the like. But do not leave cities and counties as the sole competitors for the economically disadvantaged.

Finally, I would suggest you consider expanding entitlement coverage, and putting more money into comprehensive and prevention programs that save money in the long run. A five-city demonstration program involving the Conference of Mayors is expected to show that municipal governments can improve the accessibility and affordability of health services to the poor by pooling the resources of municipal hospitals and local health departments. Participating providers were reimbursed by medicare under waivers allowed by HCFA. Initial data on the program shows that the annual cost for medicare patients was substantially less than for a similar medicare patient being served only by the public hospital.

Again, I want to thank you for the opportunity of presenting our testimony. Those of us who represent the cities and counties of this Nation are deeply concerned about the medically indigent.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Dr. Sloane follows:]

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STATEMENT OF

THE HONORABLE HARVEY SLOANE, MD

MAYOR OF LOUISVILLE

PROVISION OF HEALTH CARE FOR THE

ECONOMICALLY DISADVANTAGED

before the

SENATE FINANCE COMMITTEE HEALTH SUBCOMMITTEE

April 27, 1984

35-184 O—84——4

Mr. Chairman, members of the subcommittee, my name is Harvey Sloane. I am a physician and mayor of Louisville, and I am here on behalf of the United States Conference of Mayors.

The subject of health care for the economically disadvantaged is one that touches me personally and professionally. Mayors, as you know, are in the unique position of representing the health interests of consumers, providers and employers. The health interests of one group, the economically disadvantaged, are particularly compelling.

Who are the economically disadvantaged? We believe they are the uninsured and the underinsured. This group, according to a recent study by The Robert Wood Johnson Foundation, is made up of 21 million adults and 7 million children. Included are: those covered by medicaid, for whom coverage is incomplete - the elderly, women and children, the disabled; the working poor - who may not qualify for medicaid but cannot afford private insurance or self payment for care; and a new category, the new poor - those who have recently lost jobs and, at the same time, lost health benefits.

Let me take a moment to discuss the new poor. In cities across the country we are seeing people who are losing their jobs, exhausting their financial resources, exhausting their unemployment benefits, and losing their homes. These people are coming to health and human services agencies for the first time, and it is difficult for them to do so. Human services agencies in Evanston, Illinois reported to the Conference of Mayors in late 1982 that they have been presented with serious problems of psychological distress, alcoholism, and even violent behavior among those unable to cope with having to seek help from local agencies. Nationwide, large numbers of people ae being evicted from their homes. Families in Trenton, New Jersey, for example, because they cannot afford to do otherwise, now share their homes with others, thus living in overcrowded conditions.

Others have no home, and haven't had a home in a long while. These are the homeless. People referred to as bums, bag ladies, and derelicts. Some of the long-term homeless are deinstitutionalized people who have either returned to communities from institutions or who have not been placed in institutions. In 1965, for example, there were approximately 560,000 mentally ill persons in public psychiatric hospitals in this country. Today, because of federal legislation, court decisions, and state actions, the patient populations in those institutions have shrunk to about 125,000. We estimate that there are currently over one million chronically mentally ill persons living in communities, many of whom are homeless; requiring a variety of health and social services. Their presence in the community has increased the demand for many existing health services and created the need for development of new ones.

All of the people we have been speaking about, the uninsured and the underinsured, come to us, to cities, for health care that in some measure they cannot afford. And, though we may not be able to afford to provide it, we must and we do.

Most cities do not have statutory responsibility for the provision of health services to their citizens. This responsibility often rests with the county or the state government. Many cities, however, have taken on some responsibility for planning, coordinating, and/or administering health programs for their citizens because local needs would not otherwise be met.

Law, on the other hand, does prohibit local governments from engaging in deficit finance. So, when program needs continue or grow and available funding does not keep pace, local governments must generate more local taxes. The situation grows more complicated still for the many cities constrained by shrinking tax bases caused by a move to the suburbs of businesses and taxpaying individuals. Add to this a general economic decline plus significant cuts in federal financial assistance coupled with

reorganization of many categorical programs into block grants to the states and reductions in eligibility and benefits under entitlement programs, and you have, more or less, the situation facing cities trying to provide health care to the economically disadvantaged.

A Conference of Mayors survey of city human services officials at the end of October, 1982 identified health as the program in their department most severely impacted by federal budget cuts that year. In Atlantic City, New Jersey, for example, the rodent control program was abolished due to elimination of federal funding for that effort. The survey revealed, also, that only 30 percent of eligible populations in 55 respondent cities were served by any health provider. That was a drop of a full ten percent from Fiscal Year 1981, where 40 percent of eligible people were able to secure health services. And, 40 percent wasn't much to brag about.

Let me share some city experiences with you. Bloomington, Minnesota is a small, affluent community with an annual buget of under one million dollars. Yet, in 1980, a full ten percent of that budget, $100,000, of local tax money, went to provision of health services to low income people. A growing number of these people are newly unemployed whose presence is adding to the patient load at well child clinics, at family planning units, and on WIC waiting lists. This city, like so many others, finds itself at a disadvantage when it must compete, as Washington says it should, for patients no one else wants. In the area of home health, for instance, all providers are eager to serve four of five classes of patients: those with full medicare coverage; those with medicaid coverage; those with private insurance; and, those with sufficient personal resources to pay for their care. As for the fifth category, those unable to pay any or all service costs, there's no competition here. For the City of Bloomington, this group of people is there for the asking. There are no other takers and it is mandated that the city must serve all who need care.

without regard to ability to pay. In the days before competition was in vogue, we used to refer to this phenomenon, that of public institutions ending up with a high proportion of non-pays, as dumping.

Public hospitals and health departments in cities across the nation find themselves in a similar, untenable situation for broad categories of outpatient services.

Let me move on to some other cities. New York City's share of medicaid this year will be $.9 billion. Not included, of course, is the City's cost for care that is not covered under medicaid nor patients not covered by medicaid.

The lack of health services in Louisville also can be categorized into the three basic groups, which are the uninsured, the underinsured, and the individuals who are covered by traditional governmental third party insurers, who lack coverage in special areas.

Each of these classes of medically indigent individuals experience difficulty with access to medical services as well as difficulty in receiving services. There are approximately 195,000 uninsured and underinsured individuals in the Louisville community, and there are approximately 80,000 medicaid covered individuals. This means that approximately 40 percent of all of the residents within the boundaries of Louisville are at risk for some portion, if not all, of their medical care.

Although there is a compelling need for more funding for health services, this must be coupled with some system design changes to the present method of delivering health services. In Louisville, we are moving forward with some bold initiatives.

Particularly significant is an agreement with a private hospital corporation, the Humana Corporation, to operate the hospital which has historically provided indigent care in Louisvile. As part of a unique

agreement between city, county, and state governments, and the University of Louisville, the Humana Corporation is now providing unlimited health care to indigents at Humana Hospital University, which is also the University's teaching hospital.

In the first year of the agreement, the private corporation extended care valued at $6 million beyond the contributions of the three governments.

Through this involvement of the private sector in indigent care, the traditional public hospital has been used more, and more efficiently, to bring about a greater level of care for the poor who need it the most. This has been most timely, since the cost of hospital care has increased 61 percent in the past three years while government funding has increased only 41 percent.

Another local initiative designed to provide greater health care through participation with the private sector is ACCESS, a primary care center for the indigent in Louisville. This center is treating 120 people a day, many of whom are being spared a costly visit to the hospital by early outpatient care of their illness. Because of the successful reception of the community toward the ACCESS center concept, there will be another center operational this year.

Just this week, the Health Care Access Committee, a group established by the University of Kentucky, in its final report adopted a set of proposals urging more voluntary efforts by doctors and hospitals in providing indigent care. One of the proposals in this report would be the establishment of a hotline in medical society offices to link patients who can't afford their medical needs with physicians participating in the program. This concept has the endorsement of the State Medical Society and the Kentucky Hospital Association. If there is a fair participation among doctors and hospitals, the indigent patient load should become more widespread, thereby not becoming an inordinant burden on any segment of health providers.

Two service areas, outpatient care and pharmaceutical supplies, still reflect great needs. There is no centralized approach to improving these areas which are critical to an individual's well-being and holding down medical costs.

I feel it is important to understand the examples of local initiatives to improve health care with available resources so you will appreciate a message I'm bringing you today. And that is, cities are not simply appealing for federal funds for health care with outstretched hands. We are launching our own innovative efforts, often with local funds. But, these initiatives are not enough to meet increasing demands on public health care. An example of the increasing demand for services is demonstrated by the increasing amount of uncompensated care by hospitals in Kentucky. These hospitals in 1979 delivered $123.7 million in uncompensated hospital care, which increased to $231.6 million in 1982. This represents a 55 percent increase after the federal and state budget cuts began in 1982.

Economic and social conditions are compounding the demand for medical care by those least able to afford it. If not treated properly and quickly, the conditions of our people in cities who have no provision for care will worsen and require even more costly care later.

Where do we go from here? First, no further cuts in health services dollars. Under the guide of reducing the nation's health spending, don't cut federal dollars and shift costs to public facilities and consumers, the latter who may well not receive needed health care.

Do develop new strategies to slow the rise in the health costs. The new diagnosis related group or DRG system for example, is acceptable if it is applied across the board with a higher financial remuneration for public facilities that are providers of the last resort and for the chronically

ill, disabled or aged. For, without such provisions, it is not economically advantageous to treat such patients on a fixed rate and they are inadvertently disenfranchised from access to the health system.

Pursue the theory of competition, but do not leave cities and our county counterparts as the sole competitors for the economically disadvantaged. Give physicians financial incentives to offer quality care to this group of patients.

Consider development of a program of health benefits for the unemployed. The failure of the current system to respond to the financial and health needs of the recently unemployed people may have long reaching results.

Finally, if I may suggest an idea out of vogue, think about expanding entitlement coverage and putting more money into comprehensive and prevention programs which save money in the long run. In the late 1970's, the U.S. Conference of Mayors, The Robert Wood Johnson Foundation, the American Medical Association, and the Health Care Financing Administration joined in a five city demonstration program designed to show that municipal governments by pooling the resources of the municipal hospital and the health department are an appropriate vehicle for improving the accessibility and affordability of health care services to the urban poor. HCFA allowed waivers under medicare which permitted reimbursement to participating sites for services not normally covered and eliminated, as well, standard deductibles and co-payments. The program is winding down, and the final results are not yet in. However, preliminary data compiled by the University of Chicago demonstrate that the annual cost per medicare patient in the program was substantially less than for a similar medicare patient being served in a municipal hospital or other setting.

Senator DURENBERGER. Let me thank all the witnesses. And I will start with an observation and maybe some general questions of all of you.

It seems to me that all three of you are close enough to the situation to recognize something that the Urban Institute and others have been trying to tell us over some period of time. And that is that when our sick care bill, that is the cost of our health insurance gets up over something like 10 or 10½ percent of what we call the GNP, some very substantial percentage of the dollar that ordinary folks earn, at some point in time is taken out of the health care system.

Harvey, I think in your statement you make some specific reference to this. That this country over the last 10 years has been short shifting the poor and the near poor in the area of shelter. And running the cost of housing up so that two-thirds of the people in this country can't afford it without some sort of artificial stimulus of some kind that takes a third or 40 percent of their income. To the extent that nutritional programs in this country are getting short shifted. To the extent that recreation is getting short shifted. Now you can go right across America over the last 10 years and we really have been making it hard either for the individual on his own initiative to have dollars to put into those health care areas. Particularly for some of the population, Government seems to have done a pretty good job of pumping money into the sick care system whether it's through medicaid or John wants it in health care for the unemployed or through more home health or whatever, we have ignored this other side, which is the side that could keep people healthier.

I just wonder if each of the three of you might make some observations on that particular subject just so we can broaden the scope of what we are talking about here.

Ms. BUTLER. Yes, Mr. Chairman. The task force agrees with you that the current system of delivery of care, even to the poor, may not be very efficient. And the existing system certainly does not reward preventive health care practices. Unfortunately the way that the very meager program for financing medically indigent care in the State is designed provides only enough resources for acute and emergency services, leaving out preventive care and primary care.

We did some research and found that certain preventive practices are very cost effective. I'm sure that we could argue about some. But in the area, for instance, of prenatal care in the year after spending $1 on prenatal care, Government would save $2. And over the course of about 20 years would save $9 because of the serious disabilities that good prenatal care prevent.

Similarly, early childhood illness prevention family planning and similar programs are very cost effective. The task force therefore recommended putting more of our resources into those kinds of programs. Hopefully, not at the expense of taking care of some of the emergent and acute needs that people also have, but with the idea that over time those needs would diminish significantly.

Senator DURENBERGER. My question is going beyond that. I recognize the validity of what you say, but the Nation has a refugee policy in effect that says to Harvey or to the county, "you take care

of the problem." I mean we caused the problem that caused them to come here. And we decided to welcome them with open arms, but now that they are here, the Federal Government says it's your problem." And your problem becomes a problem of shelters, and a problem of a whole lot of other things.

I talked about housing already and what we have done at the national level to price people out of housing. And don't tell me that somehow or another a lack of adequate shelter and heat, if you are in the northern part of the country, isn't a problem. And we spend a whole lot of time dumping on the health insurance industry or on hospitals or on doctors or people not putting enough money into the health care system when it really strikes me that part of the bad guys in this whole scene are some other folks who are contributing to a deterioration of health care, if you will, in this country. And, thus, helping to raise the cost of sick care.

Dr. SLOANE. I think that's particularly significant what you mentioned about housing. Overcrowding becomes a significant health problem. There is just statistically more disease the closer people live together. Trenton, N.J., had a particular problem with that in terms of their unemployed who have gone in with their families and there has been an increased instance of sickness.

The nutrition component of health care is something that really hasn't been appreciated until recently. And we have been very poor in our medical schools in educating physicians about the importance of nutrition for an adequate life style in terms of preventing problems of obesity, et cetera.

What I think we are all getting at is that hospitalization is the last resort that we would like to not have to go to. We would like to see early preventive care. We have a gentleman in our community who is 54 years old. He had hypertension and some heart failure. He didn't have the money to seek early attention because he was unemployed. He ended up in a catastrophic care setting and it's costing $900 a day to take care of him.

Well, this is a tremendous burden on our local resources, and on any system. And we have not rewarded our whole delivery system for prevention of health and maintenance of health. I think some of the approaches for prepaid group practices or other systems have a financial incentive to keep the patient well. This should be encouraged.

I reflect back on what the ancient Chinese used to do with their doctors. They only paid them when they were well. And when they got sick, they quit paying them. And that was an incentive to keep people well.

But the whole system sort of emphasizes sickness and we need to get away from that and be able to maintain the cost and to keep people well.

Ms. KITCHEN. I would support that, and add another observation, another piece of legislation that you are working on, and that's the Natural Gas Policy Act that has significant implications in the Midwest for high utility bills. Now that doesn't cause illness, but what it does is it causes low-income people to decide whether they eat, heat, and medical care is not one of those. Those are primary costs of competing for those limited dollars.

As has been mentioned about HMO's and home health care, we strongly support those. HMO's have been an alternative for some people in the category that we are looking at. That's very valuable. And also the recommendation of catastrophic care as a solution for some people.

Senator DURENBERGER. Do any of you have any observations to made about medicaid and its relativity? What has happend to medicaid coverage in the last few years? What have States been doing with some of the opportunities we have been giving them? And would you have some observations about the medicaid population, particularly those who are just above the medicaid eligibility line. How does the current State operated medicaid program relate to this population?

Dr. SLOANE. Well, first of all, our medicaid program only covers the categorically public assistance patients, AFDC and disabled, blind, et cetera. So that whole category of people who may be underemployed, the man who is 25 years old who isn't a member of a family, he isn't covered.

What has happened in the last 3 years, the hospitalization time has been reduced to 14 days. After that, the hospital absorbs the cost. And, of course, hospitals don't want to have many medicaid patients. And one of the things that has happened with this committee that I have mentioned is that they have gotten together with the Kentucky Hospital Association and had an agreement with them to maintain the level of medicaid patients that they had in the past, and not to reduce them in the future. To reduce the benefits, the outpatient benefit, and just to cut costs anyway they can ends up by costing more because you get that end result of increased hospitalization.

We do not have a comprehensive medicaid program by any means in Kentucky.

Senator DURENBERGER. Pat.

Ms. BUTLER. Yes, I know that in the past year four states have expanded eligibility under medicaid. Ohio and Illinois have added Ribicoff children, the children in two parent families. Mississippi and Oregon have added medically needed programs for pregnant women and children. I think those are very farsighted States that recognize the value of serving those populations.

Colorado's program, like Kentucky's, is very limited. Actually I think this week the State legislature is cutting the AFDC-U program, which will mean that even fewer working poor families will have access to medicaid. So that's a very unfortunate development.

The States seem to be looking at these problems somewhat differently. Some are making progress in expanding certain kinds of services and benefits and many others are cutting back, partly because of economic problems.

Dr. SLOANE. Just one thing, Senator. I mentioned the medicaid capitation program that we have. It has been going for about 10 months. It's only with AFDC patients, and they either pick a physician or they are assigned to a physician. There is some dissatisfaction from the patients' standpoint. There has been a problem in terms of referral of specialty problems because the gatekeeper physician who gets the money for that patient has to give it to the specialist. And we haven't worked out that problem yet.

Senator DURENBERGER. The problem is of the specialist then? The specialists are resisting the process?

Dr. SLOANE. Yes. To get the primary physician to make sure that the referral process is going forward in a medically competent way.

For instance, every patient who is not in a dire emergency who comes to the emergency room has to get permission from that physician to be treated by the emergency room. And that hasn't always worked well.

We are working these things out. The medical society is quite involved. And I hope it will work out. I think it will save costs, and I hope it will give better care to the patients. But it is a form of medicaid approach that I think might save money. Well, not save money, but expand benefits. And that's what we are looking for.

Senator DURENBERGER. Let me ask you a couple of specifics about the population groups that you listed in your testimony. One reference is to the growing number of divorced, mid-life women. Obviously, if I make certain assumptions about the fact that they are going through a dissolution that involves a male of approximately the same age, and if it is in that mid-life period, I will make a second assumption about the economic status of that marriage, and maybe you can give me some information about why it is that medical insurance is not required as part of a divorce settlement or some adequate amount of money is not provided in terms of the dissolution settlement to cover that. What's the situation on it?

Ms. KITCHEN. My understanding from the legal counsel for the Older Women's League is that the courts have jurisdiction to settle pension rights, and that is within their jurisdiction. But health coverage does not fall within their domain so it would really be up to the lawyers to see that that is included. And she says that very seldom does it get included. And I have checked with some people I know and they have said that that is the case. They didn't consider it. They weren't informed. And did not have it.

But some of the spouses will carry children on their plans. But the former dependent will then look for their own coverage. So I think that could be remedied by making sure lawyers build that into the plan.

Senator DURENBERGER. Well, you know we have worked hard here in the last few months on the pension issues. A lot of it for this particular group of women. And we have worked very hard on the child support issue. But this is the first time, at least to my recollection, that the issue of mid-life divorces without adequat medical coverage has come up. And you pointed out to us that it's a substantial problem.

Ms. KITCHEN. It is. And they are the group that is most vocal and tell us the most about their experiences.

Senator DURENBERGER. There is also a reference here about the fact that it causes older citizens to pay higher premiums at a point in their life when their income is shrinking.

Ms. KITCHEN. And I'm talking about older people. And I'm talking about the medicare supplement plans. This is like over 65.

Senator DURENBERGER. Oh, I see.

Ms. KITCHEN. We are talking about in that group. And their income, for many people, would be reduced or the value of their

dollar is going down and their income is often fixed. That's why age rating is particularly harmful to them.

Senator DURENBERGER. All right.

Well, I think probably I will express my appreciation again to all three of you and ask that you follow our efforts over the next few months. We are trying in this hearing to identify the economically disadvantaged population. And at some point we will move more closely to the solution. We will ask you to continue to participate in one way or another in that effort.

Thank you very much for your testimony today.

Ms. KITCHEN. Thank you.

Dr. SLOANE. Thank you.

Ms. BUTLER. Thank you.

Senator DURENBERGER. Our final witness is J. Martin Dickler, actuary from the Health Insurance Association of America. Thank you very much for being here. You are not here to defend yourself against things that have been said about the health insurance industry. I guess we have all heard those things, which means there must be some merit to them.

You have provided a valuable service to us and to the country over the years in your annual data reporting in this area—and I understand we aren't quite to the time of the year when the latest set of statistics are available, but whatever you have, including your statement, will be made a part of the record. And you are here today to give us an overview of the problems so that we will know where to go from here.

We thank you for your testimony.

STATEMENT OF MR. J. MARTIN DICKLER, ACTUARY, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. DICKLER. Thank you, Senator. My name is Martin Dickler, I am from the Health Insurance Association of America, and I'm accompanied by James Dorsch, who is our Washington counsel.

As you mentioned, we conduct an annual survey where we collect data from all of our member companies. There are over 300 companies which write about 85 percent of the health business in the United States.

Our latest data, which is yet to be published, includes the number of persons covered in the United States as of the end of 1982. The statistics I am giving here today are being released for the first time.

Basically, our bottom line number is that as of the end of 1982, there were about 191 million Americans covered for one or more forms of health insurance. Our data from commercial insurance companies represent people covered under group policies, individual policies, and under self-insured employer programs where insurance companies perform administrative services. We also collect data from Blue Cross and Blue Shield. And we include people who are covered under other programs, such as HMO's, employee welfare plans and similar kinds of arrangements.

The figure of 191 million Americans with one or more forms of coverage is the grand total after eliminating duplication. Many

people have multiple coverage, but we have counted each person only one once, whether or not they have more than one policy.

For several years we have collected this data on the basis of two broad age categories—the age 65 and over and the under 65. Included in our 191 million are about 16 million persons age 65 and over who have bought medicare supplement plans. Those plans are very popular and range from coverages which just fill in medicare deductibles and coinsurance to the broad wrap-around policies, which include prescription drugs, private duty nursing and other expenses.

According to our data, about 65 percent of the age 65 and over population are covered under such policies.

Senator DURENBERGER. What was that percentage?

Mr. DICKLER. About 65 percent. That was as of the end of 1982. Subtracting these from the total leaves 175 million Americans under age 65 with one or more forms of health insurance coverage. It is these people that I would like to talk about today in more depth.

The total 175 million under 65 is really the same number as those who have hospital protection. Hospital protection is the most widely held form of insurance in terms of the of number of covered persons. That is why the total number with one or more forms is linked to the number of people with hospital insurance protection.

In addition to hospital protection, there is quite a bit of other coverage. About 169 million persons are also covered for surgical expense. And even more importantly, about 160 million are covered for major medical. We think that is a very important statistic, because major medical provides the broadest form of coverage available, either as a supplement to base plan coverage or under a comprehensive major medical plan.

The fact that 160 million people have major medical means that over 90 percent of Americans with private coverage have the broadest form of protection available. Now these are the numbers of covered persons, and we are here today to talk about people who do not have coverage.

We do not have very precise data on uncovered persons. On the basis of our survey data, as of the end of 1982, we would conclude that there were about 27 million people under age 65 without any private coverage. Now of that number, quite a few have medicaid coverage, VA coverage, and CHAMPUS coverage. Also included in that 27 million would be those under age 65 who qualify for medicare because of disability status. After subtracting those who are covered under public programs, on a rough basis, we believe there were about 10 to 15 million people under age 65 at the end of 1982 with no coverage at all, either private or public. And these are the people we are here to talk about today.

Senator DURENBERGER. Can you go back and remind me again of the percentage or the numbers over 65 that might have no coverage at all?

Mr. DICKLER. With respect to the number over 65, we don't think very many have no coverage, because of medicare. We don't really look upon them as being part of the uncovered population. That is why I am concentrating mainly on the under 65.

To continue, we think there were roughly 10 to 15 million persons as of the end of 1982 who had neither public nor private coverage. We see these people as falling into two broad classifications. The first are those who are in that status temporarily. These are people who move in and out of insured status for periods of time during the year, and the number can fluctuate. Our data relates to a point in time rather than over 1 month or 3 months or 1 year.

The people who are temporarily uncovered include those who have lost employment and don't have other options like continuation under a group policy, or going under a spouse's coverage, or the ability to pay for a conversion policy or other private coverage. Hopefully, they will go back into employment and once again resume their group coverage.

Other people who are temporarily without coverage are young adults who have lost coverage under their parents' policies, because of reaching a certain age, and aren't working yet. Where their parents can afford to do so, they could buy individual coverage for their children. Eventually, most young adults enter the work force and obtain group coverage, which is how most people are protected, direct their insurance coverage.

The bigger problem, we think, is the second category of people who are uncovered, and who are likely to remain uncovered for long periods of time. Here we are talking about low-income people who are chronically unemployed, do not have the money to buy individual coverage, and do not qualify for medicaid. They literally fall through the cracks.

Other low-income people may have employment, but work for firms that do not have employee health benefit programs. These people are equally unfortunate because they cannot afford individual coverage, and do not have group coverage available to them. For these reasons, the broad group of low-income people, is a chronic source of uncovered citizens.

The long-term problem area also includes people who have become uninsurable, either at a young age or middle age, and do not have insurance available to them on a nonmedical basis, such as through an employee plan, a group or an association group program. They have to purchase coverage in the open market, meet whatever underwriting requirements apply. If they cannot do that, they have a very difficult time in securing coverage, even though they might be able to afford the premium. This is not an economic problem as you have with low-income people. It's a question of developing adequate insurance mechanisms so that insurance for the uninsurable can be provided on a reasonable basis while spreading the cost across society.

We are very pleased to share our latest data with you, Senator, and I will be happy to respond to any questions you might have.

Senator DURENBERGER. Thank you.

[The prepared written statement of Mr. Dickler follows:]

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

HEALTH INSURANCE COVERAGE

Presented by

J. MARTIN DICKLER

Before the

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE

APRIL 27, 1984

My name is J. Martin Dickler. I am an Actuary of the Health Insurance Association of America, on whose behalf I appear today. I am accompanied by James A. Dorsch, Washington Counsel of the association. The Health Insurance Association of America is a trade association of approximately 320 companies which together write over 85% of the commercial health insurance in the United States.

We are pleased to have this opportunity to discuss health insurance coverage and the extent to which Americans are covered. The HIAA publisnes an annual Source Book of Health Insurance Data. The statistics assembled show the numbers of persons covered by commercial insurance companies under group and individual policies, and under non-insured plans for which they provide administrative services. Also included in our survey data are persons covered by Blue Cross and Blue Shield, and under a variety of other plans. Our most recent data, which I shall discuss today, show the numbers of covered persons as of the end of 1982. This data will be available in published form in the near future.

In order to establish an overall order of magnitude, we estimate that as of the end of 1982, over 191 million Americans were protected under one or more forms of private health insurance. Many of these persons were covered under more than one insurance policy. The 191 million is a net estimate, however, which counts persons with multiple coverage only once. The large number covered reflects the success of the health insurance industry in marketing its

products, and widespread public perception that health insurance is extremely important to have. We have seen enormous growth in coverage, considering that only 32 million were protected in 1945. One hundred ninety one million is merely the overall total, however, and we must delve deeper for a better grasp of the breath of coverage.

In our survey data, we have distinguished between persons age 65 and over and those under age 65. The total covered, 191 million, includes both age catagories. We estimate that almost 16 million persons age 65 and over had private insurance in addition to Medicare. Medicare supplementary insurance is very popular, and the almost 16 million covered represents about 65% of the age 65 and over population in 1982. There are many forms of such policies, ranging from those which cover only Medicare deductibles and coinsurance, to those which also include prescription drugs and private duty nursing.

The total number covered under age 65 at the end of 1982, for one or more forms of coverage, was 175 million. That figure represents 87% of the under 65 civilian non-institutional population. It corresponds to the number of persons who had hospital expense protection, as that is the kind of coverage held by the largest number of persons. Of course, most of the 175 million were also protected by other coverages. For example, about 169 million persons also had surgical expense protection.

With respect to Major Medical protection, our data show that 160 million persons under 65 had such coverage at the end of 1982. That is an important statistic, since it shows that over 90% of those with private insurance have major medical protection. Thus we see that Americans are not only protected in large numbers, but most also enjoy the advantages of broad based coverage.

Although the statistics show that most Americans have health insurance protection, there is still a sizeable number that is not covered. We do not have precise data in this area, but it is possible to derive a rough estimate of the uncovered segment of the under 65 population. The 175 million persons under age 65 with coverage represent 87% of that age group, which means that about 27 million persons among the civilian non-institutional population were not covered under private plans as of the end of 1982. Many of the 27 million, however, were covered under various public programs, such as Medicaid, the V.A., Champus, and Medicare for the disabled. Overall, we believe that the number of under 65 without any private or public coverage, at the end of 1982, is in the range of 10 to 15 million.

In our view, the persons without insurance seem to fall into two broad catagories. Many persons are without insurance only temporarily, as they move in and out of insured status for a variety of reasons. Examples are persons who are temporarily unemployed and

do not have other options, such as a spouse's coverage or the ability to pay for a conversion policy. Other examples would be persons who lose group coverage through other events, such as when a child reaches the maximum age for eligibility as a dependant. There are many young adults in this catagory who will either secure group coverage through new employment or who will eventually purchase individual coverage.

The second catagory of uncovered persons are those who are likely to be without insurance for long periods of time. This would include low income persons who experience chronic unemployment, and can neither afford individual insurance nor qualify for Medicaid. This catagory can also include low income persons who are employed, but work for a firm that does not have a health insurance benefit plan, and cannot afford an individual policy. Ability to pay is a major problem for low income persons when group insurance is not available at a reasonable employee contribution. Another type of uninsured in this catagory is the person who is or has become uninsurable, and does not have access to insurance without presenting evidence of insurability. The ability to pay premiums is not necessarily the problem in this case. What is required is the establishment of appropriate insurance mechanisms to offer insurance to the uninsurable on a reasonable basis.

Our industry has constantly sought methods to reduce barriers to health insurance, and we hope that the number of persons covered will increase in the future. We appreciate the opportunity to present our data and I will be pleased to respond to questions.

Senator DURENBERGER. Let me begin at the end, I guess. Who are the people that are likely to fall into the category of uninsurables?

Mr. DICKLER. Self-employed people perhaps who discover they have serious health problems, cardiovascular problems, other kinds of disability. Then if they are uninsured and they suddenly go out to buy insurance, they find they can't answer the medical questions satisfactorily.

Senator DURENBERGER. Let me take that a little bit farther. Then what happens if I have a cardiovascular history?

Mr. DICKLER. Well, they might be able to obtain coverage subject to an exclusion rider in that case, the insurer might issue an individual policy with a rider stating that the policy doesn't cover any expenses arising from a named disorder.

Senator DURENBERGER. That would be the normal course. The only other alternative that would, in effect, make them economically uninsurable is the premium. Is that available? I mean can you buy coverage that doesn't have that exclusion in it?

Mr. DICKLER. You could shop around. It depends upon your disability. There are some disabilities, Senator, where I think it would be almost impossible to obtain coverage. A person who develops severe mental or nervous disorders, schizophrenia or epilepsy. There are many disorders where most insurers would probably consider the individual totally uninsurable and could not be issued coverage.

Senator DURENBERGER. I don't want to spend a lot of time drilling this one out—but can you provide us with information relative to what various diagnoses are commonly falling in the category of exclusions?

Mr. DICKLER. We could make a survey. I could report on typical underwriting rules. The general solution to this problem is a State pool for the uninsurable. That is a solution we see for them. I have served as a director of some of these State pools, and can report on the kind of people who secure coverage that way. Often, they are people with very severe mental and nervous disorders. This is a common source of people who are uninsurable.

Mr. DORSCH. I would like to comment on that for a minute, Senator.

Senator DURENBERGER. Go ahead.

Mr. DORSCH. There are two mechanisms that I see across the country that in a spotty fashion guarantee access to insurance for this classification of people. One mechanism is that some Blue Cross/Blue Shield plans, as part of their tax exempt services, if you will, since they are tax exempt, will have an open season periodically. I saw in the paper just very recently, whether in the District of Columbia or Maryland, an open season. Regardless of your status of health, just fill out the form, send it in, and we will cover you. And that's one way. I have no information and have never been able to develop any information as to how often or in what States the Blues do, in fact, have open seasons. So I have never been able to develop any hard information on the extent of the problem as to how many people are, in fact, uninsurable. I assume, for instance, that if Maryland just had an open season, there are no uninsurables in Maryland. That doesn't mean everybody is in-

sured, but everybody that can afford it, has had an opportunity to buy insurance.

Senator DURENBERGER. Well, what happens in the pool States then? What have we got? Six of them right now?

Mr. DORSCH. In Connecticut, for instance, that program has been working there for a number of years where you have guaranteed access to coverage. But as we have testified many times to this committee and other committees, we have a problem in trying to extend these pools to other States.

Senator DURENBERGER. This is exactly the problem that I am trying to get at. I mean if you don't have information and I'm a legislator in Connecticut or let's say Minnesota, I'm stupid if I don't ask these questions first before I create a pool because if I open up the pool first, everybody is going to jump into it.

Mr. DORSCH. Now everybody won't jump into the pool because the pool price—for instance, in the State of Connecticut—is higher than what you would pay in the individual open market, if you are a healthy person. So if you are healthy, you are not going to jump into the pool.

Senator DURENBERGER. I understand that.

Mr. DORSCH. Second, most people are covered under their employer group insurance, and aren't going to get into the pool. The only people who will get into the pool are those who are falling between the cracks.

The State law in Connecticut does put a ceiling on the premium that can be charged, and it is anticipated that the pool may lose money. But the insurance industry, in seeking the legislation, successfully argued that all insurer competitors in the State should share any pool losses on an equitable basis.

Senator DURENBERGER. I know I'm not explaining this well because I haven't given it any thought, but who pushes people into the pool? I mean it might be that Blue Cross writes 75 percent of the business in Connecticut so Blue Cross is going to be 75 percent of the pool. But it's the other 25 percent of the insurers with all their exclusions for this, that and the other thing, creating a pool of the uninsurable people—am I all wet in the description of the pool?

Mr. DICKLER. Senator, I think I should explain that most people who are covered are covered under group insurance where you don't have medical underwriting. And many people with chronic illnesses are so covered, both employees and dependents.

We are talking about the much smaller market of people who seek individual coverage because group coverage is not available to them. And then a much smaller subset of that number who are, in fact, uninsurable because of some chronic disease.

Senator DURENBERGER. Rather than belaboring the point now, maybe this is a subject that we ought to explore together over some period of time.

The other side of it that I didn't get into, of course, is when people find out that heart disease is a noninsurable problem. And if the insurance industry is telling them that the first time they buy a policy, even before they have heart disease, that if you smoke, you will pay more. And I think trying to pull these two

ends together would be helpful to us in trying to decide what would be the most appropriate direction we ought to move.

Let me get to the numbers, I guess. You were here when Dr. Swartz testified. And I think the numbers she used in terms of people that would fall in this uncovered category was 38.6 million. The number you have given us is somewhere between 10 and 15.

I'm assuming you have some access to the Urban Institute study and their research and so forth. Can you tell me what is wrong with the figure that she gave us?

Mr. DICKLER. No, I'm not familiar with their study. I believe it was a study in 1979 and I'm afraid I haven't seen it.

I have seen other studies. I believe there was a CBO study that estimated the number of people in 1978 at about 11 to 18 million without coverage. There have been several studies, and the results have not been very consistent. Some studies take the people who are uncovered over an entire year and add to that anybody who is uncovered during some part of the year. I have seen numbers in the 20 to 30 million range on that basis.

It is important to understand how these numbers are put together.

Senator DURENBERGER. I will try to understand that, then. And you are going to have to help me by taking the research done by the Urban Institute and going through it. I don't want to sit here with a large number gap although it may be just definitional. If it is definitional, that's what we should be getting at here this morning.

Mr. DICKLER. Our numbers were at one point in time, at the end of 1982. They don't cover a span of months or years, and that possibly might explain some of the difference. I really don't know.

Senator DURENBERGER. Let me ask you again by way of comparison with Dr. Swartz' testimony. To the effect that many people who work in small firms or marginal industries are not covered by health insurance, is it true in your experience that that is the case? And is it a matter of the small employers being priced out of the health insurance market? Or what is the problem?

Mr. DICKLER. I think in recent years the premiums have escalated very rapidly for both small and large employers. And we have seen a very definite trend in all size groups to plans with higher deductibles and more coinsurance. I think this has been particularly true among small employers.

I'm not aware of any trend of dropping of dependent coverage. In group insurance, an employee can elect employee-only or employee-plus-dependent coverage. Now I'm not aware of any shift to employee only on the part of employees who do have dependents.

I am, however, very much aware of higher deductibles becoming popular. Smaller employers especially are switching to such plans merely to keep the premium cost inline. That is certainly true. It has also been true for very large employers, as you know from the press.

Senator DURENBERGER. Then will you also undertake to read that part of the Urban Institute study that deals with that subject?

Mr. DICKLER. Yes, sir. Be glad to.

Senator DURENBERGER. And report back to this committee as part of the record as to whether you agree, disagree or the truth somewhere inbetween.

[The information from Mr. Dickler follows:]

Memorandum
For the
Subcommittee on Health
Senate Finance Committee

On April 27, 1984, testimony was presented on behalf of the HIAA before the Subcommittee on Health of the Senate Finance Committee. At that time, Senator Durenberger requested HIAA to provide further comments on various points raised by other witnesses. This Memorandum is in response to that request.

A. Testimony of Ms. Katherine Swartz, Ph.D., Research Associate, The Urban Institute.

There were three major points in Dr. Swartz's testimony, which appear below as summarized in her statement. Each summary is followed by our comments.

1. "The number of Americans under age 65 who do not have health insurance increased by a third between 1979 and 1982, reversing a 30-year trend. In 1979, 28.7 million Americans, or 14 percent of those under age 65, lacked public or private health insurance. By 1982 the number had grown to 38.6 million, or 19 percent of those under age 65."

The HIAA was asked to reconcile its estimate of 10-15 million uncovered persons at the end of 1982, with the 38.6 million figure quoted by Dr. Swartz. The data used by Dr. Swartz were gathered by the Census Bureau in its March household surveys, when questions on health insurance coverage are asked by the interviewers. The extent of health insurance coverage reported in such surveys is subject to a variety of non-sampling errors, which result in substantial underreporting. Dr. Swartz used the numbers of uncovered persons derived from the survey without correction for underreporting, as her primary intention was to show the general change in uncovered persons over time, and not the precise number of uncovered.

In order to obtain a more refined estimate of uncovered persons from the census data, an adjustment should be made for those incorrectly classified. The extent of underreporting, however, is difficult to measure. One study, from the Rand Corporation Health Insurance Experiment, showed that 5% of persons actually covered by group insurance said they were not covered when interviewed. Underreporting may be even higher in the Census Bureau surveys. In addition to the inability to

recall information, potential errors include the inability to obtain complete information, definitional difficulties, differences in the interpretation of questions, etc. In our judgment, perhaps 5-7% of those actually covered by group insurance were included with the uncovered in the census data. According to Dr. Swartz, the data show 130 million covered by group insurance alone. That means 7 to 10 million persons actually protected under group plans could have been counted as uncovered.

With respect to the underreporting of persons covered under Medicaid, Dr. Swartz estimates, on a very rough basis, that perhaps 4 to 5 million more persons might actually be covered. In our view, there is also underreporting among persons covered by private individual plans. To account for these persons, as well as any other source of underreporting, we feel that perhaps another 2 million should be counted as covered. When these are combined with the underreporting of group insured persons, we believe that at least 13-17 million persons should be subtracted from the figure of 38.6 million uncovered. On that basis, the estimated number of uncovered persons is between 21.6 to 25.6 million persons, which is closer to the HIAA estimate of 10-15 million.

We believe there are other factors that account in part for the remaining difference with the HIAA estimate. We have not, however, attempted any further reconciliation. When estimates are derived from different data bases and methodologies, attempts to explain relatively small differences tend to become speculative. The following past estimates of the uncovered population illustrate the possible variations when different data bases and methodologies are used.

Year	Estimated Number of Uncovered all ages (millions)	Estimated by
1976	12-19	Congressional Budget Office
1978	11-18	Congressional Budget Office
1977		Wilensky and Walden
1st. Quarter	25.6	National Center
2nd. Quarter	22.6	For Health Services Research
3rd. Quarter	23.3	
4th. Quarter	24.9	

The past and current estimates all reflect reasonable approaches, and no one estimate is clearly superior to others. A conservative view, based on all of the data, might be that roughly 15 to 25 million persons under age 65 were uncovered at the end of 1982.

2. "The increase (in uncovered persons) is due in large part to the 1981-82 recession. The direct effect of the recession was that many people lost their jobs and thereby lost health insurance for themselves and their dependents. But the recession also had an indirect effect: It caused many firms to look hard at their escalating health insurance costs. Firms are now requiring employees to pay a larger share of the premium as well as more of the direct costs of health care. This has in turn caused workers to look hard at their expense for health insurance, especially for family coverage, which many decided to drop. The increase in the number of uninsured Americans due to this structural change in employers' attitudes towards health insurance will not decline as our economy recovers."

We agree that sharp rises in health care costs in recent years have led to large premium rate increases. Employers are tending to introduce deductibles in benefit areas that were formerly first dollar, and to increase existing deductibles. We do not agree, however, that employees in any significant number are electing to have their dependents uncovered, even if employee contributions may be greater than before.

The statistics cited by Dr. Swartz to support her position are that the number of uninsured children living with an insured parent increased from 1.95 million in 1981 to 4.2 million in 1982. Also, that the number of uninsured adults living with an insured spouse rose from 2.05 million in 1981 to 4.3 million in 1982. We are hesitent to accept this data as evidence that dependent coverage is being deliberately discarded. The total number of uninsured children based upon the census surveys was 14.95 million in 1981, and 14.8 million in 1982, which is a slight decrease. Thus, if there were in fact an increase in the number of uninsured children living with insured parents, there had to be an almost equal decrease in the number of uninsured children living with uninsured parents. The data is difficult to interpret, and should probably be further refined before conclusions are reached.

In order to shed more light on this matter, we contacted six of our largest member companies who write group insurance on a nationwide basis. Three of these companies could not find any evidence of a trend to decreased dependent coverage. The other three companies noted some signs of a slight decrease in the proportion of employees with dependent coverage, generally in the small group category. Each company, however, attributed that to the elimination of duplicate dependent coverage, where both parents work and both had dependent coverage. Although the data is sketchy, it may be that increased employee contributions are leading to reduced duplicate dependant coverage, but probably not the elimination of all insurance.

3. "This part of the recent increase in the number of uninsured people adds a note of urgency to the need for more diverse forms of insurance -- in particular, catastrophic health insurance."

Catastrophic health insurance generally refers to comprehensive major medical coverage with a high maximum limit. Dr. Swartz refers in her testimony to low cost catastrophic coverage, which requires substantial out-of-pocket amounts in deductibles and colnsurance. The higher the deductible, the lower the premium. As a concept, low cost catastrophic health insurance is attractive and insurance companies have been offering such policies in the individual market for many years. Potential buyers are the self-employed and others without group insurance who are willing to self insure a large deductible amount. These policies have not, however, proved to be as popular with consumers as basic coverages or low deductible comprehensive major medical. In group insurance, there has been virtually no demand for high deductible major medical coverage, unless it is to supplement a program of extensive basic coverage. If there were a demand among employers for low cost catastrophic coverage only, it would be readily provided by carriers.

Dr. Swartz may have intended that a low cost catastrophic coverage be offered as an alternative option under a group insurance plan, to be elected by low income employees. The advantages claimed for such coverage are that the low income family would be more willing to seek medical care when needed, and there would be less free care to be paid for by society. From the point of view of the low income family, however, the large out-of-pocket expense required to make catastrophic insurance "low cost" would be a

deterrent to seeking medical care. Furthermore, the out-of-pocket expense could be an intolerable burden when medical expenses are incurred, and society might bear much of the cost anyway. Much depends upon the balance between acceptable "low cost" and the required amount of out-of-pocket expense. It is not entirely clear that low cost catastrophic coverage would be a good solution.

There are other problems with high and low options under a group plan, which involve adverse selection. Each year, employees would elect the insurance plan that best serves their immediate medical needs. The working of adverse selection eventually leads to severe distortions in the premium rates for the two options, and undermines the financial stability of the group plan.

B. Testimony of Ms. Alice Kitchen - Kansas Women's Equity Action League.

The testimony presented by Ms. Kitchen describes the problems of mid-life women between age 45-65 without medical coverage, which are summarized as a lack of access and affordability. Their studies have shown that such women are either not in the work force, or work part time in low paying jobs without health benefits. They depend upon their husbands for health coverage, and, if widowed or divorced, experience many problems in securing replacement coverage.

Mid-life women in this category encounter the same problems that are faced by many persons who no longer have access to group insurance coverage. That is not to detract in any way from the emotional and economic stresses that accompany a spouse's death or a divorce. We only note that the mid-life women are a special example of all persons who lose group coverage and suffer a lack of access and affordability. If there is a unique aspect about such women, it may be that they have more difficulty securing appropriate employment and group coverage.

Ms. Kitchen identified nine specific barriers that are encountered, and we will address each of these separately.

1. COST. "Plans available to former dependents and their children generally are much more expensive than their previous group coverage. In continuation rates the dependent pays the group rate (both the employer and the employee portion), and in conversion rates, the premium is usually double the group rate. (See attachment B.) Individual rates may be less expensive but are often difficult to

acquire, do not provide comparable coverage, and may exclude various medical conditions. Only continuation rates provide the same scope of coverage. Usually the other plans have high deductible, high costs, and minimal benefits."

The two general points raised are (1) the cost of individual policies relative to group coverage, and (ii) the scope of benefits in individual policies and the underwriting rules that apply.

(i) The Cost of Individual Policies. When former dependents are able to continue under the group policy for a period of time, they generally pay the full group premium, that is, both the employer and employee share. For groups of ten or more employees, that premium is a per employee (or per dependent unit) average of several actuarial factors, such as the group's average age and sex distribution, the claims experience, occupation mix, etc. The group premium also reflects relatively low administrative expense through the economies of scale inherent in group insurance, as compared to individual insurance.

An employee or dependent who loses group coverage can usually purchase a group conversion policy. Such policies are a special kind of individual policy that must be issued without regard to the applicants health status, if applied for within a prescribed period such as thirty-one days. The premium rates for group conversion policies are age rated. The rates for older persons can substantially exceed the former group rate, which, as noted, is an average premium.

Insurance companies age rate all individual insurance policies, including group conversions, since they cannot predict in advance the age distribution of the applicants. If a company had a very large share of the individual market in a given area or state, it might be able to charge an average age premium for individual policies without incurring losses. To be successful, that company must continue to attract persons at younger than average age, to subsidize the older insureds.

The Mutual of Omaha quarterly premium rates for group conversion major medical policies were cited by Ms. Kitchen in her Attachment B. We have confirmed that the rates shown are correct. This major medical conversion plan provides very generous benefits, and covers all of the expenses usually found under a comprehensive major medical form.

Hospital room and board expense is covered at the semi-private level and physicians' charges are covered on a reasonable customary basis. A deductible and coinsurance apply. This policy is very similar to a group comprehensive major medical plan, and serves as a counter example to the assertion that only continuation under the group policy provides the same scope of coverage. In our view, the premium rates are not excessive. We have, in fact, been advised by Mutual of Omaha that substantial premium rate increases are soon to be made effective as a result of large losses.

Mutual of Omaha also offers an individual comprehensive major medical policy in its regular portfolio. That policy is similar to the group conversion major medical, and premiums are lower, although underwriting requirements apply.

(ii) Individual Policies - Scope of Benefits and Underwriting Requirements. There is a large market for individual policies and many companies actively participate. A variety of policy forms is available, providing choices among basic coverages, comprehensive major medical, and high deductible major medical policies. The scope of benefits ranges from very liberal, which is the most costly, to relatively modest coverage which is much less expensive. The public can shop to secure the best coverage they can afford. We do not agree that individual policies are difficult to acquire, or that the scope of available coverage is not comparable to group.

With respect to existing medical conditions, applicants for individual coverage are asked questions in the application about their health status. If the applicant reveals the presence of a serious disease, an extra premium may be required. When certain diseases are involved, however, such as cancer, stroke, severe mental and nervous disorders, multiple sclerosis and similar conditions, most insurers would decline to issue a policy. When such persons are aware of their condition and lose group coverage, they frequently avail themselves of the group conversion policy which is issued without reference to health status. Uninsurable persons in seven states also have an opportunity to secure coverage through an industry pooling mechanism.

It may also occur that applicants for individual policies are in reasonably good health except for a specified condition such as an ulcer, slipped disk, the presence of a kidney stone, etc. When it appears that the applicant will require medical services in the near future, the

insurer may offer to issue a policy with a rider which excludes the specific condition. Some medical conditions may be temporary and may be excluded by rider only for a short period of time.

The objectives of medical underwriting are to classify applicants by state of health to determine the appropriate premium category, and also to control last minute purchases by persons who suddenly have a need for medical expense insurance. Although these rules appear as "barriers" to applicants, the insurer could not obtain a predictable cross section of individual risks if people could purchase coverage only when needed. Group insurance can be issued without medical evidence of insurability when at least ten employees are involved, because other underwriting requirements are imposed. These are that all employees must enroll if the plan is non-contributory, and at least 75% must enroll if the plan is contributory. These participation requirements produce an acceptable cross section of risk. Since there are no corresponding safeguards in individual insurance, medical underwriting is required.

2. ACCESS. "Former dependents may or may not find out about their conversion rights. If the state has a continuation or a conversion privilege, there is a time limit. Notification of the former dependents does not always happen or happen in a timely manner. This leaves the dependent without adequate time during a very stressful period to make complicated decisions."

Every effort should be made to inform employees and dependants of any rights to continue under the group policy or to obtain a conversion policy. Conversion rights are stated in the employee's certificate of insurance, but that does not guarantee that the information has been communicated. The employer is first aware of termination of coverage, and informs the employee of available rights. The solution to this barrier probably involves improved consumer education.

Ms. Kitchen makes the point that a former dependent may be under stress and does not have adequate time to make complicated decisions. One possibility might be for such dependents to secure a group conversion policy on a non-medical basis, at least for a few months, and shop later for an individual policy that may be more appropriate. Group conversion policies often serve as interim coverage, until either group coverage is secured through new employment or some other arrangement is made.

3. Pre-Existing Condition. "Trying to secure health coverage with a pre-existing condition is like sending a youngster to school with chicken pox--they don't want the child in the group. Insurers argue that this adds an additional risk to an already high risk group. This phenomenon is called 'adverse selection.' However, I suggest to you that the insurance companies' own actuarial tables do not support this concept. (See attachment B.)"

This subject has been covered in item 1 above. The reference to insurance company actuarial tables is unclear.

4. Age Rating. "Most insurance companies except Blue Cross/Blue Shield in Kansas age rate. This practice causes older citizens to pay higher premiums at a point in their lives when their income is shrinking."

This subject has been covered in item 1 above.

5. Age Differential. "The practice of men marrying women younger than themselves can result in no medical coverage for the spouse when the worker spouse retires and becomes eligible for Medicare."

The problem raised is that of any retiree, or spouse of a retiree, who is not yet eligible for Medicare. Senator Heinz raised this question in another context by inquiring as to the availability of coverage for workers between the ages of 62 and 65 who take early retirement.

Many employers today provide coverage under the group plan for retired employees and their spouses. Such coverage is usually the same as for active employees, until the retiree and spouse, in turn, become eligible for Medicare. At that time, the coverage is changed to a Medicare supplement form of protection.

Employees who retire before 65, and do not have an employer's retiree plan, may exercise the conversion privilege. That would provide a group conversion policy for both the retiree and spouse, on a non-medical basis, until each became eligible for Medicare. If the group conversion policy was not regarded as satisfactory, the retiree and spouse could shop for individual coverage, as there are companies that will issue up to age 64. In addition, there is at least one large association of retired persons that offers its membership group coverage at ages under 65.

6. Part-Time Employment. "Dependents as well as single workers employed in part time low paying jobs usually have no access to health benefits."

If an employer has a group health plan, it is usually available to full time employees and those that work at least 20 hours per week. Thus, it is possible that workers who are employed for less than 20 hours per week may not be eligible for the group plan. Although this is a barrier, the issue of how many working hours should be needed to qualify for group benefits is debatable.

7. Insurer Bankruptcy or Employer Termination of Group Plan. "This problem affects all formerly insured members in a critical way. There is little recourse for these members; however, according to the Kansas Insurance Commission office, companies under the jurisdiction of Chapter 11 may eventually pay off the claims they owe."

   Most carriers are financially secure and insurer bankruptcy is a relatively rare event. When it occurs, the State Insurance Department usually takes action to protect the interests of policyholders, to the extent possible.

   Insurers cannot prevent an employer termination of a group plan. If the plan is insured, however, the insurance company is responsible for any claims incurred prior to the effective date of termination, provided the employer paid all due premiums.

8. Medicare Age. "This is not currently a problem. However, if the recommendation of the Social Security Advisory Council is implemented and the age is raised from 65 to 68, we will see a further widening of the gap for those without medical insurance."

   The availability of insurance for retirees not yet eligible for Medicare was covered in item 5 above. If the Medicare age were raised from 65 to 68, we would expect that present arrangements and options would continue to be available for the added three years.

9. Self-Insuring. "The Employee Retirement Income Security Act, ERISA, has in its legislation a title that covers employee fringe and health benefits. This section spells out administrative procedures for fiscal matters, reporting and disclosure practices for self-insured plans. Because these self-insured medical plans that fall under the jurisdiction of the ERISA law have minimal standards, many employers are now choosing to self-insure, thereby escaping the scrutiny of the State Insurance Commissioner. Other reasons companies self-insure are to avoid state premium tax and

regulations. Under the regulatory vacuum of ERISA, companies can write plans that do not cover certain medical conditions, thereby excluding coverage that has been deemed necessary and humane by many state insurance commissions."

A self insured employer is able to avoid state premium tax and other state laws and regulations that apply to insured plans. Although reference is made to ERISA, the ability of employers to self insure long predates that legislation. The trend toward self insurance on the part of large employers began in the early 1970s, and was also motivated by financial advantages in becoming self insured.

Although self insurance is not new with respect to large employers, there has been more self insurance in recent years involving smaller size groups. Small groups cannot self insure in the sense of taking the financial risk of their own claims experience. Instead, small employers join self-insured multiple employer trusts that are organized by third party claim administrators, which compete with insured group plans designed for small employers. The HIAA fully supports the concept of insured plans and state regulation of insurance.

J. Martin Dickler
Actuary

5/24/84

Senator DURENBERGER. Dr. Swartz recommended to us among other things a need for low-cost catastrophic health insurance coverage and for more choice among health benefit plans. I wonder if you might just comment on trends in that area among employed populations and the trend in the insurance industry of making available a variety of plans, including low-cost catastrophic benefits.

Mr. DICKLER. Well, low-cost catastrophic plans are only low cost if you have a high front-end deductible. That's what makes them low cost. I have been involved in health insurance for over 25 years, and in all of those years, I have never seen high deductible plans sell well either on a group basis to employers, or in the individual market to individuals.

I believe Americans by and large want first dollar coverage, and they are only turning away from it now slightly because of the high cost. When I say we are seeing shifts to higher deductibles, I'm talking about $100 deductibles going to $200 and $300. In another 2 or 3 years they might reach $400 and $500. But with the escalation of health care costs, after you adjust for inflation, these really aren't high deductibles.

In order to bring premiums down to what might be called low price, you have talk in terms of front-end deductibles of possibly $1,000 to $2,000 and higher. Many companies offer individual major medical policies with high front-end deductibles—$1,000, $2,500. I even know of a company that offered a $10,000 deductible policy.

Traditionally, however, sales of such policies have never been high in the individual market, and I don't know of any group buyers interested in that kind of coverage.

Senator DURENBERGER. Ms. Kitchen in her testimony talked about a variety of problems that mid-life women have with the in-

surance industry to go beyond the need for unisex insurance, which I won't even ask you about. But among these issues is the issue of cost. And I think you heard her testify that the plans available to former dependents and their children generally are much more expensive than their previous group coverage. And the continuation rates for dependents when the dependent pays the group rate and both the employer and the employee portion, the premium is usually double the group rate.

Attachment B, which I don't fully understand, is a Mutual of Omaha quarterly premium table for major medical conversion plans. And it shows how, depending on this deductible, there are quite a disparity in rates between males and females.

Would you discuss the problem that she raises for us?

Mr. DICKLER. I think I can if we are talking about a divorce situation that occurs when the woman is in her 40's or 50's and she is not working herself—and that is what the problem is. If the divorced wife or husband, whatever the case may be, is employed, and continues to have group coverage, I don't think there is a problem situation.

The problem is when you have the traditional homemaker who suddenly finds herself without a spouse, maybe a meager divorce settlement, and very little funds with which to purchase insurance. If she could find employment where there is group insurance, that would be her best alternative. If not, she is probably in the category of low-income persons without access to group coverage, who have to shop in the individual market or possibly buy a policy through mass enrollment. That is a problem she shares with many uncovered people who are low income.

I believe quite a few women in that category experience cultural shock because they didn't formerly consider themselves to be low-income people, but that's exactly what they wind up being.

Senator DURENBERGER. I hate to keep using you in this way, but I guess that's what you are here for. I wonder if you wouldn't take a look at the testimony on behalf of the Women's Equity Action League in Kansas where they deal with a variety of these kinds of issues—cost, access, preexisting condition, which we have already dealt with, and age rating, age differential, the problems of self-insurers and so forth—and then perhaps address some of the questions that were raised here at various times. John Heinz raised it relative to the under 65 population group. Give us your opinion of what the insurance industry is able to do and why it has to do some of these things that it is doing so that we will have it as part of the record.

Would you be able to do that?

Mr. DICKLER. Be happy to.

Senator DURENBERGER. Would you give us some idea about what is happening on the self-insurance side? I know it is sometimes a problem for you, and sometimes not. But it seems to be creating a problem for some people, including some employers who have decided to go that way. Maybe if you could just give us a little overview of the impact that the trend toward employer self-insurance is having on either the cost or the availability or the benefit structure in health insurance.

Mr. DICKLER. I would be happy to, Senator. I think it's a question of perspective. Self-insurance didn't begin with ERISA, although I think ERISA stimulated interest in self-insurance. Many of the large corporations of our country have self-insured their group insurance programs for many years, while maintaining a very close relationship with their insurance companies. The carriers continue to do many of the things that an insurer would do anyway even though they no longer bear the financial risk. They continue to process claims, prepare employees' certificates, provide conversion policies, et cetera. Many large corporations would go self-insurance and little would really be changed.

It was a financial arrangement more than anything else. In recent years there has been more of a tendency for self-insurance to be adopted by smaller-and-smaller groups. We have seen the growth of what we call TPA's third party administrators. There have been many firms go into the claims processing business and solicit small groups who participate on a totally uninsured basis. The employees have their claims processed, and the employer pays, I suppose, what he thinks is a premium or something similar to a premium. It's all right as long as the funds are there to pay the claims, but the benefits are not insured. The plan is not under any State regulatory system. Many States I think, are trying to figure out how to regulate such arrangements. No conversion policies are provided. You have none of the usual safeguards that have grown up over the years in a regular insured program.

Senator DURENBERGER. What happens with regard to mandated benefits. I mean when the legislature in Colorado mandates a set of benefits. Does that apply in the self-insurance situation?

Mr. DICKLER. Normally, Senator, these laws only apply to group or individual policies issued in that State.

Senator DURENBERGER. You get stuck with the mandates.

Mr. DICKLER. We get stuck with the mandates. They do not apply to self-insured programs, whether a large or small employer is involved.

One of the big problems of mandates, is when they apply on an extra territorality basis. That is a problem for groups with employees in several States since it can disrupt a nationwide employee benefit plan.

Senator DURENBERGER. All right, thank you very much.

Thank all the witnesses this morning. And I hope that you will all stay in touch and follow up on the directions you got this morning. I appreciate it. The hearing is adjourned.

[Whereupon, at 11:30 p.m., the hearing was concluded.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

STATEMENT OF

THE AMERICAN PROTESTANT HEALTH ASSOCIATION

SUBMITTED TO

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

HEARING ON

HEALTHCARE FOR THE ECONOMICALLY DISADVANTAGED

APRIL 27, 1984

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STATEMENT OF THE
AMERICAN PROTESTANT HEALTH
ASSOCIATION ON HEALTH CARE
FOR THE ECONOMICALLY DISADVANTAGED

Mr. Chairman and Members of the Subcommittee, the American Protestant Health Association ("APHA") appreciates this opportunity to present its views on the critical issue of health care for the economically disadvantaged. We commend the Subcommittee for holding hearings to examine this important issue in depth.

The APHA is comprised of 300 institutions, agencies and nursing homes across the country, and with 2,000 personal members in its division, the College of Chaplains. The APHA has hospitals in 38 states, totalling 60,000 beds, and its hospitals are located in both rural communities and the inner cities. Although the APHA hospitals are church-related, they receive little or no direct financial support from the church.

As an indivisible part of their religious commitment, the APHA hospitals serve large proportions of Medicare, Medicaid and charity care patients. With respect to the latter, the term "charity care" may be defined as the provision of health care services to patients lacking Medicare, Medicaid, Blue Cross, or other third party insurance and who are otherwise unable to pay for medical services. Such patients generally are chronically and terminally ill and impoverished citizens; often, too, they are unemployed. Thus, the APHA

hospitals are, in effect, "safety net" institutions of last resort for citizens, irrespective of the severity of their illnesses or inability to pay for medical services. Recent data indicates that the safety net institutions, such as the APHA hospitals, have resulted in the reduction of health care costs and the increase in competition in our health system, while continuing to provide health care services to unemployed and uninsured persons. The services provided by these hospitals are clearly of benefit to the Medicare and Medicaid programs, other insurors, the health care system and the community at large.

Therefore, it is crucial that such safety net hospitals continue to be able to provide the greatly needed medical services they now offer. Historically, philanthropy paid for a substantial portion of the costs associated with charity care. These philanthropic subsidies declined with the advent of Medicare, Medicaid and the growth of private insurance, which generally will not reimburse for charity care. Hospitals with large numbers of charity care patients now face significant threats to their financial viability in the short-run because of inadequate cash flow and in the long-run because of limited availability of capital funds. This follows since hospitals with the largest charity care burdens, by definition, have a smaller pool of charge-paying patients on whom to shift the burdens associated with the former. Thus, these hospitals may not be able to pay promptly their creditors and employees

and may not have sufficient retained revenues with which to finance capital projects. Their access to debt also may be adversely affected by their low cash flow.

In order for safety net hospitals to be able to provide a vital community service, their special requirements must be taken into account. In this respect, the APHA urges that the special needs of their hospitals (and other hospitals providing charity care) that are in financial distress because of their providing uncompensated charity care be considered and addressed by the Congress. These shortfalls are not alleviated by the Medicare/Medicaid programs or third party insurors and are exacerbated because of the growing concern about financially distressed hospitals. For instance, the National Center for Health Services Research of the Department of Health and Human Services has estimated in its Report, dated June 1983, that between one-quarter and one-third of voluntary hospitals are unable to generate sufficient revenues to pay expenses, in part, because of their providing services to patients who are unable to pay for them. It is precisely because charity care patients are ineligible for Medicare/Medicaid or other insurance that they fall into a twilight zone of health care which is being met by safety net institutions on an uncompensated basis.

The APHA, therefore, urges this Subcommittee to identify certain criteria which would provide the basis of some form of assistance to those hospitals which are reaching the point

of becoming financially distressed. For instance, such criteria may include whether the hospital in question is serving such charity care patients, the percentage of such patient population and the effect on the hospitals' financial health of providing charity health care. Any equitable assistance program, however, should not erode the marketplace forces now at work in the health care industry. We would urge the Congress to have the Department of Health and Human Services take the necessary first step by reporting to the Congress by December 31, 1984 on the scope and parameters of this issue.

The APHA wishes to stress that it is not advocating a program of national health insurance for hospital services. To the contrary, the assistance called for by the APHA should be provided only to those hospitals which are in financial distress because of their providing charity care to patients unable to pay their bills.

In conclusion, the APHA believes that it is vital that hospitals receive some form of assistance to enable them to continue to provide charity care and that the assistance itself be separate and distinct from the Hospital Insurance Trust Fund. We appreciate this opportunity to present our views on these vital issues, and the APHA stands ready as a resource to work with the Congress and the Department of Health and Human Services in the months ahead to develop a system which will protect the public and the financially distressed hospitals.

Statement of the National Association of Chain Drug Stores, Inc.

BEFORE THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TASK FORCE ON FEDERAL PRESCRIPTION REIMBURSEMENT POLICY

SEPTEMBER 12, 1983

NACDS
National Association of Chain Drug Stores, Inc.
P.O. Box 1417-D49
Alexandria, Virginia 22313
703-549-3001

INTRODUCTION

Mr. Chairman and Members of the Task Force:

I am Vincent Gardner, Vice President of the National Association of Chain Drug Stores (NACDS). My background includes degrees in both pharmacy and business administration. In addition, I have taught economics and business at the School of Pharmacy, University of California at San Francisco from 1957 to 1967. From 1968 to 1979 I served in various positions within the Department of Health, Education and Welfare. My last position was Associate Administrator for Pharmaceutical Reimbursements of the Medicaid Bureau, HCFA, and Chairman of the Pharmaceutical Reimbursement Board. Accompanying me today is Nancy Buc, formerly FDA General Counsel and now in private practice.

I believe I have a rather comprehensive understanding of the Department's pharmacy reimbursement regulations since I served on the committee that helped draft many of them for HEW Secretary Casper Weinberger. I was then given the just punishment of having to administer them. During that time I attended or presided over many meetings on these regulations, and I empathize with the members of the Task Force. I wish to express my thanks for allowing NACDS to testify today.

The National Association of Chain Drug Stores is a non-profit trade association which represents more than 160 chain drug store

corporations operating over 15,000 pharmacies throughout the United States. Since the inception of the Medicaid program, both NACDS and its individual members have worked closely with the Department and state Medicaid administrators in an effort to develop policies that will provide prescribed drugs to beneficiaries at reasonable cost to taxpayers.

The Association and its members are particularly concerned with two parts of present regulations covering reimbursements for prescribed drugs. They are the sections which:

- limit reimbursements to the lower of (1) ingredient cost of the drug product, [1] not to exceed the federally established MAC limits, if applicable, plus a dispensing fee, or (2) the pharmacy's usual and customary retail price [2]; and,
- the new regulations which require pharmacies to provide services even though a recipient cannot pay a state imposed co-payment.[3]

We have over the past two and one-half years requested the Department to review the "lower of" provisions, and have recently asked the Secretary to review the co-payment rules. We are deeply concerned that these provisions which both our members and the members of the National Association of Retail Druggists (NARD) believe should receive the most attention were not mentioned as areas of concern in the announcement of this meeting. We hope that this was

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1. The ingredient cost is the price the pharmacy pays its supplier -- a manufacturer or distributor of the drug.
2. 45 CFR Part 250.30.
3. 48 Fed. Reg. 5731 (Feb. 8, 1983).

an unintended oversight by the Task Force and not an indication of disinterest in the concerns of pharmacy owners.

We believe in the necessity of providing prescription drug benefits to the needy persons in our society and intend to continue to provide those services. But without some relief in these two areas many pharmacies will be unable to remain in business in spite of their overall efficiency of operation. Although these regulations have to some degree always operated unfairly against retail drug stores, industry developments in recent years have made them particularly onerous. As more fully explained below, they now not only deter efficiency and competition among retail drug stores, but also make participation in the Medicaid program a losing proposition.

If the Medicaid program is to remain effective, changes in the reimbursement system must be made. I wish to address these two areas separately.

"LOWER OF" PROVISIONS

The retail price of a prescription consists of three components: (1) the ingredient cost of medication; (2) other costs, including rent, salaries, inventory carrying costs, administrative costs, and utilities; and (3) a reasonable profit, which rewards the pharmacy owner for investing capital and assuming the business risks associated with operating a prescription department.

Pharmacies commonly use one of two pricing methods in arriving at retail prices. The first of these methods involves a percentage mark-up on the ingredient cost of medication. When the ingredient cost is low, the mark-up may not fully cover all the other costs mentioned above, much less a profit. In other cases, when the ingredient cost is greater, the percentage mark-up will cover other costs and profit. This pricing system produces a profit when the average mark-up (in dollars) exceeds all costs.

The second, and much less common, pricing method is to add a fixed dollar amount to the ingredient cost of the product. This fixed dollar mark-up or fee is based upon the assumption that the other costs (i.e., other than the cost of the drug) are the same for all prescriptions and are not related to the cost of the drug product. When the product cost is high, however, the basic assumption no longer holds, because the inventory carrying charge for drug products varies directly with the cost of the product.

Which ever pricing system - percentage mark-up or fee - serves as the basis of retail price, the actual retail price will be modified innumerable times, usually because of competition. Thus, just as some products in grocery stores serves as loss leaders, so may particular prescription drugs. When a competitor reduces a price, other drug stores may have to do the same. A new pharmacy may have a grand opening sale on drug A, and others in the neighborhood will

respond by meeting or beating the price on drug A or by slashing thei own prices on drugs B and C. In short, in order to remain competitive, drug stores must meet and beat prevailing market prices, whether or not those prices correspond to the price determined by the basic pricing system.

The Medicaid "lower of" regulations exploit this situation by comparing the competitively set market price of a drug against a price determined by a fixed regulatory formula and then choosing the lower of the two. The usual and customary price will be lower than cost plus fee when the product is a loss leader or otherwise subject to intense competition. Cost plus fee will be lower than the usual and customary price when the cost of the drug and/or the state-set dispensing fee has been allowed to fall below market levels.[4] Thus, the Medicaid regulations set up a classic "Heads I Win, Tails You Lose" situation: when the usual and customary price is higher than the government-set cost plus fee, Medicaid reimburses only the latter; when the cost plus fee is the higher, Medicaid pays only the usual and customary price. Medicaid in effect purchases all drugs whose prices are low because of competition and all drugs whose prices are low because of regulation, never giving the pharmacy a profit large enough to cover the losses.

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4. See page 6.

Significantly, if Medicaid were the sole purchaser of prescription drugs, pharmacies would have no incentive to compete on price. If they simply set the usual and customary charge higher than the cost plus fee amount, they at least would guarantee themselves the government-set price, which, as discussed below, is itself often inadequate.

INADEQUATE REGULATORY FORMULA

The inequities of the "lower of" squeeze are compounded by the frequent inadequacy of the state-set dispensing fee. For example, if a drug's ingredients cost more than the state allows, or if the drug store's actual mark-up (reflecting its costs and a small profit) are above the state-set dispensing fee, which is supposed to cover gross profits, Medicaid participation results in not only no profit, but actual loss.

State-set dispensing fees are a serious problem. When the government first promulgated the "lower of" regulations, mark-ups were about equal to acquisition costs. Since then, however, ingredient costs have risen, which means the pharmacy must expend more in inventory costs. But state-set dispensing fees have not kept pace. As a result, the dispensing fee does not cover other costs, much less a profit.[5] Remember, too, that when the dispensing fee is artificially low becuase the states have not raised it, the "lower of" squeeze will occur more and more often. The problem is

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5. A recent study by California State University, Chico, underscores this point. This study concluded that "Higher product costs directly affect pharmacists, who face even larger dollar investments, while at the same time dispensing fees are tending to rise at a slower rate. The resultant disparity has created a situation wherein the return on inventory for pharmacists has gradually decreased for most products, and dramatically decreased for others." The High Costs of Therapy by Dennis L. Hefner, Ph. D., California State University, Chico (1983).

further exacerbated when ingredient price limits are lower than the pharmacist's actual acquisition cost.

In summary, the pharmacy has three opportunities to lose money under Medicaid reimbursement regulations: once because of the "lower of" provisions, once because the dispensing fee is too low, and once because the ingredient cost paid is too low.

The result is that pharmacists are subsidizing Medicaid. To impose these costs on one particular segment of society - indeed one particular type of provider which is necessary to the success of the Medicaid program - is both illogical and unfair. Congress, in passing the Medicaid Act and its subsequent amendments, has continually demonstrated its intent to prevent providers from being made involuntary Medicaid cost-sharers, and this intent should be honored. [6]

It is, moreover, simply illogical to place this burden on pharmacists. As Medicaid becomes more and more expensive for drug stores particularly, many will be forced out of business, thereby limiting the ability of recipients to take advantage of Medicaid services and

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6. The Kerr-Mills Act, for example, which contained the original Medicaid Act, required Federal Medicaid assistance to be "100 percentum less the state percentage," 42 U.S.C. 1396d(b), evidencing Congress' intent to fund the program entirely from state and Federal contributions. The 1965 Amendments to the Act underscored this point, again stating that participation by the States was to be equal to all of the non-Federal share, so that lack of local funding would not affect the benefits provided. 42 U.S.C. 1386a(a) (2).

reducing competition which will increase health care costs to private consumers. No doubt this turn of events will also cause additional frustration with and animosity toward government programs, leaving a significant and important segment of society feeling not only alienated, but taken advantage of as well. The vital role played by drug stores, as well as the ease with which the problems created by the "lower of" provision could be avoided merely by repeal, suggests that effective action should be taken quickly.[7]

In the absence of some remedial action, pharmacists will be forced to compensate for losses generated by Medicaid sales by charging higher prices to private patients. Since the elderly currently account for approximately 26 to 30 percent of all prescription drug expenditures, this cost shift will create a situation in which they will be forced to spend more of their income on health care. This will in turn reduce their disposable income, and, ironically, add to the ranks of Medicaid (and to the cost of the program to taxpayers). In addition, as prices to private consumers rise, third party premiums will rise, adding to the already sprialing national health care costs.

This trend could be slowed, if not entirely stopped, if the "lower of" provision were simply eliminated and pharmacists were allowed to charge Medicaid competitive market prices. Such action would

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7. Drug stores have in the past made prescription benefits one of the most cost-effective portions of the program. In fiscal year 1982, Medicaid reimbursements for drugs were $1.59 billion and accounted for 5.3 percent of total Medicaid payments. For such effectiveness to be undermined because of inequitable reimbursement policies would be a great tragedy.

not significantly raise the cost of Medicaid. Indeed, the "lower of" provisions have never saved the government much money. Alternative plans could insure efficient Medicaid service without burdening the retail drug industry. For example, if, as NACDS recommends, reimbursements were based upon market prices (the usual and customary charge to the general public), an upper limit at the 90th percentile of all charges in the state for the same product could be imposed to ensure that the Government would not pay unnecessarily high prices.

THE COMPETITIVE RETAIL DRUG MARKET

As more fully discussed below, the competitive nature of the retail drug industry assures the delivery of low-cost high-quality drug products and services to all consumers, whether they pay their own bills, have private insurers pay them, or have Medicaid pay them. Despite this strong competition, however, government regulation rather than competition has played the leading role in setting rates for Medicaid pharmaceutical reimbursement. In other words, instead of reimbursing prescription drug purchases at the same competitively set prices available in the open market, Medicaid agencies reimburse pharmacists at price levels determined by various regulatory formulas. Over time, such regulation has, predictably, introduced distortions and unfairness into the reimbursement formulas. Moreover, the regulatory mechanism is itself costly. Since competitive forces are more

than adequate to hold down retail drug prices, and since the taxpayers' money must be used to pay for all this extra regulation, it is time to take a hard look at how to inject more competition and less regulation into Medicaid reimbursement for prescription drugs.

The existing Medicaid reimbursement system is very much the product of a different era in public policy thinking. If we were starting from scratch to decide how to do Medicaid reimbursement, terms like competition and regulatory reform would be in the forefront of our minds. But when Medicaid was first adopted, the benefits of competition and the drawbacks of overregulation had not yet entered the public dialogue. Thus, like many other programs of the 1960's, Medicaid used regulation as the means of defining reimbursement systems and setting amounts to be reimbursed.

Each attempt to fine tune Medicaid introduced additional layers of regulation. NACDS believes the time has now come to go back to square one, and to design a Medicaid system which, by taking advantage of existing strong competition, holds down retail prices and reduces regulation and its associated disadvantages and costs.

Such substitution of competition for regulation is now generally recognized as desirable when there is reason to believe that competition would have a beneficial effect. Experts believe that

industries most susceptible to deregulation are those in which conditions of competition, service, quality, and the economy no longer justify ponderous and complicated control processes.[8] Retail pharmacy is just such an industry. We believe this is the intent of this Administration as expressed by the President and Secretary Heckler. We do not understand the hesitancy of the Department to act according to its words.

A recent study[9] conducted by the Federal Trade Commission's Bureau of Economics found that, although health care does differ from other service industries in a number of ways, many segments of the industry offer the opportunity for, and could benefit from, competitive-based policies. Although the study found no reason to contend that competition is appropriate for all segments of the health industry, neither did it find any reason to think that regulation is appropriate for all health care markets. The best solution, the study concluded, is to approach the health care field on a service-by-service basis. In general, the closer the market resembles the competitive ideal, the less likely it is that some regulatory intervention technique will lower the price of goods or improve the allocation of resources.[10]

The retail drug industry is one area which already fits this competitive model. As the following discussion illustrates, drug

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8. Clark, Koster, and Miller, ed., Reforming Regulation, American Enterprise Institute For Public Policy Research (1980), at 19.

9. Competition and Health Planning: An Issues Paper, ("study") by Judith R. Gelman, Division of Industry Analysis, Bureau of Economics, Federal Trade Commission (April 1982).

10. Study at 13.

stores today constitute one of the most competitive segments of American business, delivering prescription drugs and services at low cost with high efficiency. This segment of the health care industry is, in short, the type of market best able to regulate itself without government interference. The government could and should take advantage of existing market conditions in this field by reimbursing pharmaceutical providers at the same prices at which similar drugs and services are offered to other customers, and not, as is currently done, at prices determined by artificial regulatory formulas. In this way, the 75% of consumers who pay for their own prescriptions [11] can be used as a barometer of fair price.

Strong competition and low profits have long characterized the retail drug industry. Nearly twenty years ago, in a case charging price discrimination by a retail drug store, an FTC hearing examiner found that "it should come as no surprise to anybody that net profit margins, as percentages of gross sales, are not very high in the retail drug industry. In the Matter of William H. Roper, Inc., 69 F.T.C. 667 (1966). In reviewing the hearing examiner's decision, the Commission found that "the evidence of record demonstrates that there is intense competition in the retail drug industry. This finds support in the fact that profit margins in the industry as a whole are approximately 5%." Id. at 725. Since this case was decided,

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11. American Druggist, May, 1982 at 12.

several factors - most notably, the growth of large retail drug store chains and the advent of retail drug price advertising - have intensified competition in the industry and ensured that the price of retail drugs remains at the lowest possible level.[12]

The number of drug stores now in business offers simple but powerful testimony to the competitive state of the industry.[13] There are currently over 50,000 pharmacies in the United States. Especially in metropolitan areas, this translates into very low store-to-customer ratios and often signifies an extremely small market share for any one company. Among chain stores, the intensity of competition is further borne out by the fact that, although only two cities support as many as six major chain drug competitors, dominance by a single chain is the exception rather than the rule in the nation's top 50 markets.[14]

Current prescription drug data bear out the fact that competition in the sale of prescription drugs has kept price increases to a minimum. Although the average prescription price in chain drug stores increased from $4.72 in 1975 to $7.24 in 1980, an increase of about 53%, the average cost to the pharmacy of drug products

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12. In contrast to the retail sale of prescription drugs, much criticism has been directed at what are often considered excess profits associated with the manufacture of drug products. While there is still a great deal of scholarly debate over whether such profits do exist, or if they do, whether they are justified, there has been a marked absence of similar allegations with regard to retail drug profits.

13. The Supreme Court has stated that "competition is likely to be greatest when there are many sellers, none of which has any significant market share." U.S. v. Philadelphia National Bank, 374 U.S. 321, 363 (1962).

14. Chain Drug Review, April 26, 1982, at 62.

dispensed during that same period increased by more than 75 percent. Indeed, the average gross profit during this period increased by less than 30 percent. More recent statistics reflect a continuation of this trend of higher acquisition costs for pharmacies and of higher retail costs to consumers, without a corresponding increase in drug store profits. According to Pharmaceutical Data Service, the retail price of prescriptions rose 11.3% in 1982. Drug store acquisition costs for the average prescription, however, was up 18%, thereby reducing overall drug store profit margins from 3.3% of sales to 3.2%. [15]

A study of inventory costs compared the ingredient costs and gross profits for the top four drug products in six therapeutic categories in 1975 and 1982. The average ingredient cost in 1975 was $3.49 (or 57.26% of retail price) and $8.91 (or 70.07% of retail price) in 1982. The gross margin for the same time periods were $2.61 (or 42.74% of retail price) and $3.81 (or 29.94% of retail price) respectively. [16] This gives further evidence to the highly competitive nature of the retail drug market. In a less competitive market, the relationship between ingredient cost and gross margin would have remained relatively similar.

A comparison of price increases for prescription drugs with increases for medical care in particular and for all consumer items in general highlights the impressive performance of competitive market forces

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15. Drug Topics, November 22, 1982 at 37.

16. Hefner, op. Cit.

in maintaining low prescription drug prices. In the ten year period from January 1973 to January 1983, the Consumer Price Index (CPI) for all consumer items rose 129.1%, from 127.7% to 292.6%. The CPI for medical care, furthermore, rose 157.8%, to 347.8% in 1983 from a 1973 level of 134.9%. In contrast, the CPI for prescription drugs experienced only a 102.9% change in this period, rising from 100.6% in Janaury 1973 to 204.1% in January 1983. This increase was 54.0 percentage points less than that experienced by other medical care, and 78.3 percentage points less than the average of all other consumer items.[17]

There is no reason to believe that this trend of relatively stable prescription drug prices will change in the future. Prescription drug sales continue to increase each year, and will almost certainly continue to do so in the future, given that people over 55 years of age tend to use a disproportionately large amount of drugs, and that this age group is growing at twice the rate of the entire United States population.[18] As prescription sales move ahead faster than total sales, drug stores will become more dependent for growth on prescription volume. Drug stores therefore have an incentive to maximize prescription drug sales, which in turn requires that prescription products and services be sold at favorable prices. This incentive to increase volume - which in turn is most likely to occur when prices are lower - is especially strong because, in general, as prescription activity increases, total drug store

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17. Percentages derived from Bureau of Labor Statistics, U.S. Department of Labor.

18. Drug Topics, July 5, 1982.

expenses decline faster as a percent of sales than do gross margins, hence resulting in a higher net profit for stores with greater prescription demand. This in turn, is good news for the consumer, since prescription sales increases generally mean an overall decrease in prescription drug prices. [19]

Moreover, unlike some other segments of the health care delivery system, prescription drugs are frequently advertised, itself an assurance that prices will stay down as consumers use the advertisments to decide where to shop. [20] Indeed, since the Supreme Court decision in Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. 748 (1975), invalidated restrictions on the advertising of retail pharmaceutical services and products, there has been an explosion of retail drug advertising. [21] This advertising has already helped to save millions of dollars. See Staff Report to the Federal Trade Commission, Prescription Drug Price Disclosures 119 (1975).

The retail drug market is a fast growing, highly competitive industry which offers consumers the full advantage of an active, free market economy. Traditional indicia of competitiveness - low profit levels, extensive advertising of products and services, and small market shares divided among several companies - all underscore the accuracy of this characterization. Government health care policies could best

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19. 1982 NACDS - LILLY DIGEST at 12.

20. See Federal Trade Commission, Staff Report on Advertising of Opthalmic Goods and Services and Proposed Trade Regulation Rule (1971) (advertising prices of opthalmic goods would lower prices).

take advantage of these market factors by simply allowing them to work for Medicaid in the same way they work for other consumers. If pharmacies participating in Federal and state health care programs were reimbursed at market level prices, both the provider and the government would benefit, and the current discontent resulting from expensive, time consuming, and ultimately unnecessary regulations would be alleviated, if not entirely eliminated.

CONCLUSION

Prescription drugs are an important part of health care in the United States. They are vital to a successful government health care program which ultimately saves taxpayer's money. However, efforts must be made to alleviate the burden on pharmacists in dispensing Medicaid prescriptions, in order that the full advantages offered by prescription drugs can be realized. NACDS believes the repeal of the "lower of" provisions is essential to the survival of a viable Medicaid program. NACDS endorses efforts to contain Medicaid costs, but opposes those ill conceived plans which shift costs and burdens to providers and to private sector patients. This shift is unfair and, in the long run, impractical.

NACDS is especially distrubed that HHS would publish its prospective reimbursement regulation for hospitals which do not pay at the "lower of" costs or charges yet continues to enforce such a provision on pharmacies. Secretary Heckler, in announcing this new regulation,

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21. 83.7% of the chain drug stores and 71.9% of the independent drug stores which responded to a recent advertising survey indicated that they actively promoted their prescription drug products. Drug Topics, July 19, 1982 at 40.

charged that the old system "failed to reward efficiency." This regulation applies to one of the least competitive segments of the health care market. Yet the Department does not reward efficiency in the retail drug market, a highly competitive market. We believe this inconsistency is grossly unfair to pharmacy.

We recommend that the Medicaid regulations be amended so as to reimburse pharmacies at the usual and customary charge up to the 90 percentile of all charges in the state. This would reduce the cost of regulation to society, reward efficiency, allow the competitive market to work, and minimize Federal and state Medicaid expenditures.

CO-PAYMENT PROVISION

Now, if I may, I would like to address the co-payment provisions. Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") partly in order to reduce Federal expenditures under the Medicaid program. By allowing states to impose cost-sharing charges such as co-insurance, deductibles, and co-payments on categorically needy individuals, Congress sought to minimize the cost of Medicaid without rendering it unavailable to intended recipients. Congress believed that requiring a minimal contribution from recipients would both discourage overuse of Medicaid services as well as help, however, minimally, to reduce the cost of the program. Notwithstanding the theoretical soundness of this goal, whatever Medicaid cost savings there have been come not at the

expense of either the government or individual participants in the program, but at the expense of innocent program providers. As discussed below, this unintended and unfair result, created by HCFA co-payment regulations implementing TEFRA's cost-sharing provisions, falls most heavily on pharmaceutical providers, and directly contravenes both the law and common sense.

THE REGULATIONS ARE BURDENSOME TO DRUG STORES

On February 8, 1983, HCFA promulgated final interim rules to implement TEFRA's Medicaid provisions. In relevant part, these rules state:

> A state plan must provide that the Medicaid Agency may limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid for by the Agency plus any deductible, co-insurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost-sharing amount imposed by the plan in accordance with Section 447.53. 48 Fed. Reg. 5731 (Feb. 8, 1983).

The effect of these rules on providers is self-evident. On the one hand they must accept as maximum payment from the government an amount less than the full cost of the services rendered. On the other hand they may not deny services to individual program recipients when, as frequently happens, the recipients are unable to pay the required co-payment. Although providers retain a legal "right" to the unpaid amount, in practice that right is both

illusory and undesirable. No provider wants to bring, nor if it wants to, can it affort to bring, a collection action for two or three dollars against someone who is by definition truly needy. Providers are left with one alternative: to absorb the unmet costs. When the provider is a drug store, that means not only foregoing a profit, but suffering a financial loss as well.

The illegality of these regulations is discussed below. Unlawfulness, however, is really only a secondary reason for urging their amendment. The first, more important reason, involves both fairness and common sense. Why should providers, who are obviously essential to the success of the Medicaid program, suffer a significant financial loss for assuming a role which enhances the public good?

The Medicaid Act made the state and Federal governments partners in providing medical goods and services to those who previously were unable to afford them. Although the opportunity to impose limited cost-sharing measures on some recipients has been a part of the program since 1972, Congress did not intend that Medicaid be subsidized by providers. Medicaid is funded by tax dollars, apportioned and collected from all segments of society, and contributed to in small part through cost-sharing by those who directly receive its benefits. To impose, as the co-payment regulations now do, additional costs on one particular segment of society -

esepcially one which is necessary to the success of the program - is both illogical and unfair. It is also unworkable, at least with respect to drug stores, for they, among all providers, are the least able to bear these additional costs.

DRUG STORES ARE PARTICULARLY DISADVANTAGED BY THE NEW REULATIONS

Drug stores are more susceptible to financial losses under this regulation than are other providers. The low profit margin, the highly competitive market in which pharmacists practice, and the correspondingly low rate of prescription drug price increases in spite of large manufacturer's price increases, have already been discussed. When drug stores are unable to collect co-payments from Medicaid recipients, they, unlike other providers, are often doing so on services which either do not turn a profit in the first place, or on which the profit margin is so small that even minimal losses make a large difference.

Co-payments are not a small tax on an otherwise profitable deal. They are the last straw in a transaction which was already weighted against the pharmacist. Significantly, other providers, such as hospitals and doctors, are not so disadvantaged by co-payments, because they render substantially more expenseive services than do drug stores. A three dollar co-payment loss is much less noticeable

to a hospital, which often presents a bill for thousands of dollars, than it is to a drug store, which presents a significantly smaller bill. Co-payments, in fact, represent anywhere from 8% to 109% of a drug store's dispensing fee. Together, pharmacies stand to lose a total of more than $43 million a year under the new regulations in those 21 states with co-payment rules.

The following table demonstrates the magnitude of the problem pharmacies face. For example, in Alabama the co-payment for a prescription drug with an acquisition cost of $50.00 is $3.00. The state-set dispensing fee is $2.75. Under the "lower of" provision of the regulation maximum payment to a pharmacy would be $52.75. If the patient does not pay the co-payment, the pharmacy would receive only $49.75 for the prescription. This is $.25 less than the pharmacist paid for the drug product. In other words, Medicaid reimbursement would not even cover the product cost.

This brief summary demonstrates the major problems with which drug stores, as participants in the Medicaid program, must cope.

THE CO-PAYMENT REGULATIONS ARE ILLEGAL

The Administrative Procedure Act provides that agency regulations are invalid if they are "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right" or are

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POTENTIAL PHARMACY LOSS FROM MEDICAID CO-PAYMENT REGULATION

State	Total Co-Payments*	Dispensing Fee	Co-Pay	Co-Pay as % of Fee
Alabama	$ 1,678,450**	$ 2.75	$ .50	18
			1.00	36
			2.00	73
			3.00	109
California	20,811,060	3.60	1.00	28
D.C.	387,893	3.27	.50	15
Idaho	177,797	2.50-3.50	.50	14-20
Iowa	932,141	3.53	.50	28
Kansas	1,306,269	1.60-4.23	.50	12-31
Maine	534,251	3.20	.50	16
Maryland	625,624**	3.25	.50	15
			1.00	31
Michigan	4,408,165	2.65	.50	19
Mississippi	1,621,473	3.17	.50	16
Missouri	1,811,727**	2.50	.50	20
			1.00	40
Montana	242,978	2.00-3.75	.50	13-25
Nevada	181,726	3.78	1.00	27
New Hampshire	476,481	2.70	1.00	37
New Mexico	156,798	3.15	.25	8
North Carolina	2,048,741	3.00	.50	17
South Carolina	954,232	3.03	.50	17
South Dakota	103,123	3.00	1.00	33
Vermont	475,826	2.50	1.00	40
Virginia	1,167,352**	2.85	.50	18
			1.00	35
West Virginia	494,552**	2.75	.50	18
			1.00	36
Wisconsin	2,907,441	3.40	.50	15
Total	$43,230,277			

* Probable loss to pharmacy under current law

** State has a variable co-payment based on cost of prescription. Co-payment underestimated, based upon lowest co-payment rate.

"arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." § 706 U.S.C. (2) (A) and (c). The regulations violate both standards and therefore must be changed.

With regard to the legislative authority for the regulations, neither TEFRA nor any of the preceding statutes dealing with Medicaid demonstrates a Congressional intent to make providers Medicaid cost-sharers. Yet the new co-payment regulations put drug stores in essentially this position by prohibiting denial of services to Medicaid recipients who do not pay their co-payments, without also requiring that state or federal funds be used to reimburse the provider for lost revenue.

TEFRA does not, for example, authorize regulations which mandate that the responsibility for collecting unmet co-payments be that of the pharmacy - that idea was HCFA's alone.[22] TEFRA in no way suggests that the pharmacist should bear the loss of unmet co-payments, nor does it prohibit a provider from seeking recourse against the state or Federal Medicaid agency for the uncollected amount. Insofar as this is the result of the regulations, they cannot stand.

The legislative history of the original Medicaid Act and of its subsequent amendments offer additional authority for the proposition

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22. See Pub. L. No. 97-248, § 131, 96 Stat. 369 (1982).

that Congress did not intend to have providers help support the Medicaid program. TEFRA, for example, contains no legislative language indicating that Congress wanted providers to bear the responsibility of either collecting or absorbing [illegible] co-payments; indeed, a review of the revelant legislative history provides evidence to the contrary.

For instance, the House Report accompanying H.R. 6877, a Medicaid cost-sharing bill which preceded TEFRA and directly influenced its wording, explicitly provided that states should not impose any cost-sharing burdens on providers:

> "The Committee recognizes that in many instances it may be difficult for providers participating in the program to collect even nominal co-payments from indigent beneficiaries. The Committee does not intend that the States use the authority to impose co-payments in order to reduce provider reimbursements. H.R. Rep. No. 757, 97th Cong. 2d. Sess. 5. (emphasis added)

Although H.R. 6877 was not enacted, the conference on TEFRA resulted in the current co-payment provisions, which clearly track the statutory language of H.R. 6877. [23] This demonstrates that when Congress passed TEFRA, it understood the origin and scope of its co-payment provisions to be the same as those which were originally part of H.R. 6877.

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23. Joint Conference on S. 4961, August 3, 1982.

The TEFRA amendments to the Medicaid Act were by no means the first time Congress demonstrated its intent to prevent providers from being made involuntary Medicaid cost-sharers. In fact, the 1982 amendments reflect a principal, fundamental to Medicaid legislation from the start, that all costs to providers be fully reimbursed. The Kerr-Mills Act, for example, which contained the original Medicaid Act, required Federal Medicaid assistance to be "100 percentum less the state percentage." 42 U.S.C. § 1396d(b), evidencing Congress' intent to fund the program entirely from State and Federal contributions. The 1965 Amendments to the Act underscored this point, again stating that participation by the States was to be equal to all of the non-Federal share, so that lack of local funding would not affect the benefits provided. 42 U.S.C. 1396a(a)(2). The Senate Report accompanying the Amendment erased any remaining doubt as to the meaning of this provision:

> "The reasonable cost of service ordinarily provided ... would be paid for ... since the cost of the services would be covered, hospitals would not be deterred, because of non-paying or underpaying patients in this aged group, from trying to provide the best of modern care. S. Rep. No. 404, 89th Cong., 1st Sess. reprinted in 1965 U.S. Code Cong. and Ad. News 1943, 1967-68. (emphasis added).

Congress' aim of reimbursing the full reasonable costs of all providers has remained constant. While subsequent amendments have

expanded the range of services offered, they still do not authorize the imposition of costs on those who provide the services. Because the new co-payment regulations do impose such costs on providers, they are invalid.

The adverse effect of these regulations upon providers also renders them arbitrary and capricious, in violation of Section 706(c) of the Administrative Procedure Act. Under this standard of review, agency actions are invalid if they violate some fundamental policy, whether it be constitutional, statutory or otherwise. Because it is counter to the purpose and intent of the Medicaid Act to leave providers less well off than when they entered the program, the regulation clearly breaches just such a fundamental statutory policy. The regulations are arbitrary and capricious because they not only deprive providers of that which was implicit in the statute (a minimum profit), but also of the amount the provider is forced to absorb from uncollected and uncollectible co-payments. Indeed, the regulations also violate a fundamental constitutional policy, insofar as the loss the regulations impose on providers so nearly constitutes a "taking" as to be in violation of the due process clause of the constitution.

THE REGULATIONS ARE PROCEDURALLY DEFECTIVE

Section 553 of the Administrative Procedure Act requires that an

agency provide notice and an opportunity for comment before promulgating regulations. Failure to follow this procedure renders the ensuing regulations invalid. There are two exceptions to the procedural requirements of Section 553 - that the absence of notice and comment was for "good cause" or that the rule is interpretative rather than substantive in nature. HCFA asserted both grounds in its statement accompanying the final rules, but neither is valid.

HCFA first asserted that it had good cause for waiving the opportunity for notice and comment because it had to act quickly in order to conform the pre-existing Medicaid regulations to the changes required by the TEFRA amendments. "Good cause," however, can only be properly asserted when there is an emergency, American Federation of Government Employees, AFL-CIO v. Block, 655 F. 2d 1153, 1156 (1981). Here HCFA waited four full months before publishing the regulations, scarcely an indicator of an emergency. In any case, a brief 30 day comment period would have been consistent with the TEFRA timetable, and allowed NACDS and other interested parties to comment before the regulations went into effect.

The agency's claim that the rules were interpretative rather than substantive fares no better than its good cause argument. The

preamble to the final rules states that because the statute does not give the Secretary discretion to change classes or categories of participants upon which cost-sharing may be imposed, these regulations are merely interpretative. This assertion is simply wrong; if the rules do not actually change the class of participants upon which cost-sharing is imposed, they at least have a significant substantive effect upon providers, which for all intents and purposes makes them a new class of participants.

PROPOSED POLICY

The policy and legal shortcomings of the Medicaid reimbursement system require in-depth study by the Department both as applied to providers in general and to drug stores in particular. NACDS believes, however, that given the disadvantageous position already occupied by pharmaceutical providers, immediate action with respect to the co-payment regulations is required. As explained above, these regulations impose an additional and unacceptable burden on drug stores, and will ultimately work to the detriment of both drug stores and the Medicaid program as a whole. NACDS believes, therefore, that, at least as applied to drug stores, the Department should amend these regulations to allow drug stores the right to recoup from the government lost revenue resulting from unmet co-payments. The amendment could leave the government with

the option, if it wishes to exercise it, of collecting these co-payments from recipients at some later date.[24] The relevant regulation, 42 C.F.R. § 447.15, could be amended by simply adding a concluding sentence stating that "the provider shall, however, be fully reimbursed by the state Medicaid agency for all unmet cost sharing amounts."

CONCLUSION

The inequities of the new co-payment regulations require that they be amended immediately. NACDS is firmly committed to this goal, and will take whatever action is necessary to achieve it. We anticipate, however, that agency co-operation and action will help solve the problem quickly and efficiently.

NACDS and its members stand ready to work with the Department to develop rules which will allow the free market to work to the advantage of the Medicaid drug program. As pharmacy owners, our members implore this Task Force to first direct its attention to the major problems of the pharmacy providers -- the "lower of" and co-payment provisions -- before dealing with other sections of the regulations.

I thank you for the opportunity to appear before this Task Force today.

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24. Shifting the burden of collection back to the government (where Congress originally intended it to be) also avoids potential problems which might otherwise be created if the amendment simply gave drug stores the right to deny services to those unable to pay for them. The goal of pharmacies is to provide services quickly and efficiently to those in need of them; it is not to cross-examine or deny services to those who cannot or will not pay. Congress structured the Medicaid Act so that health care professionals would not be put in such a position. It would be fundamentally unfair and offensive now to make them assume such a role.